

**MOA MEMBERS
FROM SUE A. WEINGARTNER, EXECUTIVE DIRECTOR
APRIL 14, 2009**

JOINT BOARD CERTIFICATION PROJECT TEAM

Link to the AOA Joint Board Certification Project Team Information:
<http://www.aoa.org/JBCPT.xml>

The Joint Board Certification Project Team has issued a model for optometric board certification which will be reviewed at the AOA House of Delegates in June in Washington, D.C. The House of Delegates will decide whether to approve or reject the model. The project team included representatives from AOA, AOSA, ASCO, ARBO, NBEO and the American Academy of Optometry. The model establishes standards for voluntary board certification and maintenance of certification in the practice of optometry.

If you have not already done so, please review the information on the AOA website (see link above), as well as review the additional information attached to this email. The link is also posted on the MOA website: www.mteyes.com

We look forward to hearing your ideas and questions about board certification. We plan to send a survey regarding health care reform and board certification to you within the next couple of days. Please take a few minutes to complete it as it will be helpful information in moving forward in the discussions.

Certainly, there will be different opinions, questions and concerns—we need to get them all out on the table. Please don't be silent when it is so vitally important to your profession, to the MOA and the AOA to hear your opinion. We look forward to seeing you in Great Falls. Please let us know if you have any questions or suggestions.

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Continued Competency – A Colorado Approach

Most consumers already assume that when a professional is re-licensed they are fully competent to do their job. For the most part, their assumption is correct. However, with today's fast-paced, technology-driven world, it is necessary for professionals to continually update their skills and knowledge in the field. Relying solely on on-the-job experience is not always sufficient. We seek a new approach to ensure competency among professions.

Continued Competency is a movement that requires professionals to demonstrate their competency in their field, usually by means of assessment against a standard, ranging from an initial self assessment, to a peer review, or even published articles in a recognized journal. Currently in many areas, we rely solely on continuing education requirements, which allow the professional to attain further knowledge via classroom work, but the number of hours sitting in the classroom does not accurately show that the professional is competent in terms of changing professional practices and modified job requirements.

In order to seek input from the professions that will be held accountable to this standard, DORA requests feedback and partnerships with interested professionals and associations to develop a statewide Continued Competency initiative that makes sense for Colorado. DORA's goal in instituting Continued Competency is to develop a system that protects Colorado consumers, fits our types of practices and our regulatory environment, and supports Colorado's professional culture.

We stand committed to the following principles as we solicit input and pursue partnerships to develop Colorado's Continued Competency system:

- There should be collaboration. A broad collaboration of stakeholders is necessary to develop effective programs. This must include licensing, accreditation and certification entities as well as associations, societies and other interested parties.
- One size does not fit all. We believe that different professionals will require different models/approaches.
- The purpose is to assure public safety and improve the lifelong learning of professionals, not catch "bad apples."
- It is the professionals' responsibility and benefit. Any continued competency program should be designed as a positive development in the professional's career, not as an unwarranted intrusion or punitive burden.
- Continuing Education, while not necessarily sufficient by itself to ensure Continued Competence, may be a necessary component.
- The final responsibility to develop initiatives that work for each profession should reside with the licensing board or entity responsible for licensure.
- Any system should address the knowledge, skills, attitudes, judgment, abilities, experience, and ethics necessary for safe and competent practice in the setting and role of an individuals' practice at the time of renewal.
- Any system must take into account existing professional development programs administered by voluntary credentialing and specialty boards or by hospitals or other employers, when the private programs meet Board-established standards.

ABMS National Policy Forum Underscores Value of Aligning ABMS MOC with National Healthcare Policy Reform Movement

Evanston, Ill. - April 8, 2009 - The American Board of Medical Specialties (ABMS), recently convened major stakeholders in healthcare policy reform for its first National Policy Forum (NPF) addressing physician accountability and the role of physician standards in achieving improved healthcare performance and effectiveness.

Keynote speaker Janet M. Corrigan, PhD, MBA, president and chief executive officer of the National Quality Forum (NQF) confirmed the critical need for involvement from the physician community. "If we are going to have meaningful healthcare reform, we need to have everyone on board," said Dr. Corrigan. "The new administration and Congress are off and running, so your voice is really needed. Now is the time to ensure that board certification is aligned with efforts to improve quality, cost and care."

The forum, held March 17, 2009, in Washington, D.C., provided ABMS and representatives of its 24 Member Boards the opportunity to meet with leaders in purchaser, government and consumer groups who are involved in improving healthcare value in the United States. The event included panelists from major purchaser groups, U.S. Senate staff, and national consumer organizations.

One theme during the panel discussions was support among major stakeholders for ABMS Maintenance of Certification[®] (MOC) as a method for increasing physician accountability. Panelists said that MOC – a key ABMS priority – should be included in healthcare reform legislation as a way for patients, health insurers and policymakers to know that providers are delivering effective, quality care.

"It is no longer enough for physicians to indicate they are board certified; they must maintain their certification," said Barry M. Straube, MD, director and chief medical officer of the Centers for Medicare and Medicaid Services (CMS), who delivered the NPF opening keynote address. ABMS MOC "aligns perfectly with what we are doing at CMS," said Dr. Straube. He added that one idea for including MOC in healthcare reform would be to count it as a Physician Quality Reporting Initiative (PQRI) measure.

A second theme of the forum discussion was the need for evidence to demonstrate the link between MOC and healthcare quality and the reduction of costs, two primary goals of healthcare reform. Dr. Straube stated that making this connection is essential, because right now we don't have evidence that MOC-participating physicians deliver better quality care. "I think we all believe it, but we don't have the evidence," said Dr. Straube, adding that reporting data on MOC will provide the needed connection for policymakers.

ABMS was created more than 75 years ago as a reliable and trusted resource for consumers and healthcare professionals seeking information on physician qualifications. "In establishing MOC, ABMS furthers its ability to "assure patients, health insurers and policymakers that commitment to quality among the physician community is continuing," said Kevin B. Weiss, MD, ABMS president and CEO after the forum.

Reporting performance data has been unpopular with some physicians who see it as an unfair evaluation tool, but the panelists said doctors need to understand that policymakers believe that reporting will

increase quality and lower costs. “I think there is a role for public reporting and I don’t think it is going to go away,” said Dr. Corrigan.

Panelists representing patients and health insurers said they believe MOC-based reporting will provide consumers with the information they need to distinguish between physicians who deliver effective, quality care and those who do not. But Peter V. Lee, JD executive director of National Health Policy for the Pacific Business Group on Health added that employers want MOC to be reported “not so insurers can play gotcha, but so consumers can make better informed choices among all the physicians available to them.”

Helen Darling, MA, BS, president of the National Business Group on Health, confirmed that initial interest among purchasers is in being able to distinguish good from bad care, but that long term, what they are looking for is improvement in care. “Eventually, there should be a difference in payments based on what the reporting shows,” said Joyce Dubow, senior advisor in AARP’s Office of Policy and Strategy.

“While physicians understand the demands of maintaining certification, patients need to understand that MOC is different than licensing and that while licensing is done state-by-state, MOC is nationwide,” said Kavita Patel, MD, MSHS, deputy staff director of the Senate Health Committee. Lee added that because most of the state licensing boards oversee only the most minimal level of physician competence, it will be helpful to make transparent the data underlying the board certification process and ongoing MOC criteria.

ABMS has taken several steps to address the need to align MOC with national healthcare reform by developing more rigorous reporting standards, through programs such as its Enhanced Public Trust Initiative, launched within the past year, and implementation of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient survey. Corrigan asserted that incorporating CAHPS with MOC requirements is extremely important. Debra L. Ness, MS, president of National Partnership for Women and Families, agreed. “It is not enough for doctors to say they care about patients if they aren’t willing to take the step to ask their patients for feedback,” said Ness.

ABMS also recently became a member of the NQF’s National Priorities Partnership (NPP), a group of 28 “stakeholder organizations” that Corrigan said is aiming to improve safety, care coordination, patient and family engagement, palliative care and the general health of the population while reducing unnecessary medical costs. The NPP initiative goes beyond simple reporting. Corrigan explained, “A lot has been done on quality but we have only seen modest improvement. We have focused on measurement and not enough on improvement.” She also acknowledged that while the partnership is moving faster than some want, “we don’t have the luxury of moving at a snail’s pace anymore.”

According to Chris Dawe, a staff member for the U.S. Senate Finance Committee, the Finance Committee plans to introduce healthcare reform legislation this summer. He noted, stakeholders in healthcare reform are looking to the physician community to embrace transparency as a necessary element in the effort to create incentives that reward quality care and efficient use of resources. “Things are moving rapidly,” said Dawe, “And we are interested in working on something that works. Opportunities like this come around only once every 10 or 20 years.”

“I think the ABMS participants all came away with an increased sense of urgency about the need for transparency in physician accountability,” said Joel A. DeLisa, MD, MS, ABMS chair. “This was a pivotal opportunity for our Board Enterprise to hear from and align our efforts with national leaders in healthcare reform.”

About ABMS

Now in its 75th year, American Board of Medical Specialties is the medical organization overseeing physician certification in the United States. It assists its 24 Member Boards in their efforts to develop and implement educational and professional standards for the evaluation and certification of physician specialists. ABMS Member Boards provide physician certification information to ABMS for its certification verification service programs. ABMS is recognized by the key healthcare credentialing accreditation entities as a primary equivalent source of board certification data for medical specialists. Patients can visit www.abms.org or call toll-free 1-866-ASK-ABMS to see if their physician is board certified by an ABMS Member Board. For more information about ABMS visit www.abms.org or call (847) 491-9091.

The 24 Member Boards that make up the ABMS Board Enterprise covers over 145 medical specialties and subspecialties include: American Board of Allergy and Immunology, American Board of Anesthesiology, American Board of Colon and Rectal Surgery, American Board of Dermatology, American Board of Emergency Medicine, American Board of Family Medicine, American Board of Internal Medicine, American Board of Medical Genetics, American Board of Neurological Surgery, American Board of Nuclear Medicine, American Board of Obstetrics and Gynecology, American Board of Ophthalmology, American Board of Orthopaedic Surgery, American Board of Otolaryngology, American Board of Pathology, American Board of Pediatrics American Board of Physical Medicine and Rehabilitation, American Board of Plastic Surgery, American Board of Preventive Medicine, American Board of Psychiatry and Neurology, American Board of Radiology, American Board of Surgery, American Board of Thoracic Surgery, and American Board of Urology.

Health Insurance Exchange

Americans aged 55 to 64 through a Medicare buy-in,

The plan would provide every American living below the poverty level with access to Medicaid.

The Baucus plan would also ensure that all states use the State Children's Health Insurance Program (CHIP) to cover children at or below 250 percent of the Federal poverty level, putting help within reach for more needy children. Finally, recognizing that America cannot keep its promise to provide care to Native Americans and Alaska Natives with the current level of Indian Health Service (IHS) funding, the Baucus plan calls for additional funding for IHS.

Once affordable, high-quality, and meaningful health insurance options are available to all Americans through their employers or through the Exchange, individuals would have a responsibility to have health coverage. This step is necessary for insurance market reforms to function properly and to end the cost shifting that occurs within the system. It is expected that the vast majority of American employers would continue to provide coverage as a competitive benefit to attract employees. Except for small firms, employers that choose otherwise must contribute to a fund that would help cover those who remain uninsured.

Improving Health Care Quality and Value. Recognizing that any attempt to cover the uninsured and reduce health care spending must address the perverse incentives fostered by current payment systems, the Baucus plan includes delivery system reforms that would improve quality and, over time, lower costs. The plan strengthens the role of primary care and chronic care management. Primary care is the keystone of a high-performing health care system. Increasing the supply and availability of primary care practitioners by improving the value placed on their work is a necessary step toward meaningful reform. The plan would refocus payment incentives toward quality and value. Today's payment systems reward providers for delivering more care rather than better care. A redefined health system would realign payment incentives toward improving the quality of care delivered to patients. Fixing the unstable and unsustainable Medicare physician payment formula is a necessary step in this process. The plan would promote accountability and coordination among providers by encouraging providers in different settings — physician offices, inpatient hospitals, post-acute care settings, and others — to collaborate and provide patient-centered care in a way that would improve quality and save money. To facilitate the proposed delivery system reforms, the Baucus plan would improve the health care infrastructure by investing in new comparative effectiveness research and health information technology (IT). Health IT is needed for quality reporting and improvement and to give providers ready access to better evidence and other clinical decision-support tools. Reinvesting in the training of a twenty-first century health care workforce is necessary for many delivery system reform goals to be realized.

The plan would increase transparency of cost and quality information

Figure 1.5. Lack of Consensus on Reform Options

45%
39%
36%
31%
**Tax Breaks to
Make Insurance
More Affordable
Individual
Mandate
Medicare-for-All
Employer
Mandate
Support Oppose**

Source: Los Angeles Times/Bloomberg poll, Oct 19-22, 2007
Policymakers

Patient-Centered Medical Home. Expanding Medicare’s role in testing the medical home model — in which practitioners are paid explicitly for comprehensive care management services — is another way that the Baucus plan would promote quality and efficiency. A growing body of evidence suggests that medical homes may improve patient health and reduce costs.^{8,9} In 2006, Congress required CMS to establish a demonstration program to test the medical home model in fee-for-service Medicare.¹⁰ More recently, Congress provided additional funding for this demonstration and granted CMS authority to expand the program if quality and cost targets are met.¹¹ Medical home expansions in Medicare should focus only on providers who are committed to ensuring that patients truly receive the primary care and care management services that the medical home is designed to deliver. Providers seeking to participate in a Medicare medical home expansion program should meet a set of stringent service and capacity criteria in order to qualify, such as those proposed by MedPAC,¹² and be willing to have additional payments based in part on the quality of care they deliver. The National Committee for Quality Assurance (NCQA) has also developed an assessment tool that tiers medical homes based on the implementation of particular capacities and patient services.¹³ In addition, careful consideration should be paid to the role of non-physician providers, such as nurse practitioners and home health aides, in the medical home model. Medical home expansions should also target the patient populations most in need of comprehensive care management and coordination, particularly those with multiple chronic conditions. As with other components of the medical home, though, these tools and criteria will evolve as results from ongoing demonstrations and input from patients, providers, other stakeholders, and experts are received and incorporated into the medical home model.

This plan would expand the medical home model by requiring collaboration between Medicare and ongoing demonstration sites that include private payers and Medicaid. Aligning incentives created by disparate payment models — for example, private payers and public programs — is crucial to achieving significant delivery system reform.

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REFOCUSING PAYMENT INCENTIVES TOWARD QUALITY

Efforts to restructure provider payment systems to improve quality also represent a critical component of delivery system reform. Many private and public organizations have echoed the need to re-direct the health care system to reward higher quality and more efficient care. In its landmark 1999 report, *To Err is Human: Building a Safer Health Care System*, the Institute of Medicine (IOM) urged a heightened focus on quality initiatives.¹⁹ Subsequent reports called for increasing payments for providers offering high-quality care²⁰ and the establishment of a national system for performance measurement and reporting.²¹ MedPAC has also made multiple recommendations to Congress regarding the need for payment incentives based on quality for hospitals, physicians, home health providers, Medicare Advantage plans, and outpatient dialysis providers.^{22,23} Based on these recommendations, Congress and CMS have enacted and implemented policies to increase the focus on quality in the Medicare payment systems, particularly in the areas of inpatient hospital care and physician services. The Baucus plan will build on these efforts by establishing a pay-for-performance program for hospitals in Medicare and further strengthening physician programs that are focused on quality improvement. The plan will also encourage efforts to test pay-for-performance models related to home health and nursing home care, as well as bring pay-for-performance to the Medicare Advantage program.

Hospital Quality Reporting and Next-Generation Quality-Based Payment Reforms.

In 2003, Congress set the Medicare program on a path toward quality improvement by establishing a hospital pay-for-reporting program.²⁴ As part of this effort, Congress asked hospitals to track and report to CMS their performance on a set of ten defined quality measures, such as how frequently a heart attack patient received aspirin upon admission. To encourage participation, Congress provided higher payments to hospitals that reported this information, and penalized those that did not. Ninety-eight percent of hospitals chose to participate.²⁵

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In 2005, Congress permanently extended the reporting program, directed CMS to incorporate additional performance measures into the initiative,²⁶ and increased penalties for non-participating hospitals.²⁷

By most accounts, the Medicare hospital pay-for-reporting program has been an important first step in improving the quality of care provided to Medicare beneficiaries in the inpatient hospital setting. It provides better insight into the quality and performance of America's hospitals for policymakers and patients alike.

Alongside the Medicare pay-for-reporting program, CMS has been testing a more aggressive move to a "pay-for-quality" model. In October 2003, CMS contracted with Premier, Inc., a nationwide alliance of not-for-profit hospitals and health systems, to

conduct a demonstration linking payment to the achievement of quality goals. This project, the Hospital Quality Incentive Demonstration (HQID), has involved more than 260 hospitals across the nation²⁸. Under the demonstration, hospitals were asked to report process and outcome measures in five clinical areas related to heart attack, heart failure and pneumonia. Hospitals in the top 20 percent in each clinical area received a financial incentive payment.

Results from the HQID project demonstrate dramatic quality improvements in every measured clinical area, with an 11.8 percent average quality improvement among participating facilities over two years. These statistics translate into actual results for patients: 1,284 fewer heart attack deaths for patients who received more clinically appropriate care²⁹. Based on these results, the HQID demonstration was extended for another three years (through 2009) and will be expanded to test other innovative pay-for-performance models.

The next step in quality-based payment reform is the adoption of a value-based purchasing (VBP) program in the hospital inpatient setting. In its November 2007 Report to Congress, CMS provided a roadmap for moving Medicare from pay-for-reporting to pay-for-performance.³⁰ In establishing a pay-for-performance program, providers would not only be rewarded for reporting quality activities, but their payment would also be increased or decreased depending on how well they perform on these quality measures.

Building on these recommendations and the other efforts outlined above, the Baucus plan includes provisions to improve quality care in the inpatient hospital setting through establishing a hospital pay-for-performance program, which is sometimes also referred to as value-based purchasing, in Medicare. The Baucus plan uses the following principles to guide this effort:

Transitions to value-based purchasing should be gradual. Linking payments to performance represents a major shift in how Medicare pays for services. The plan would phase in value-based purchasing so that the amount of payment at risk would gradually increase to no more than two percent of base hospital operating payments.

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Quality measures should be endorsed by relevant stakeholders. All measures must be evidence-based, statistically valid, and field-tested to ensure that they represent the best practices in improving quality. Measures should be selected through rulemaking and endorsed or considered by consensus-building organizations whenever possible.

Rewards should be provided to hospitals that achieve quality goals as well as to those that make significant improvements. The value-based purchasing program should reward facilities that meet quality benchmarks and those who have made substantial quality gains in performance relative to prior years.

Every effort must be made to align hospital and physician quality goals. As new quality measures for hospital and physician performance continue to be developed, every effort must be made to encourage providers to work together toward common quality improvement goals.

Physician Quality Reporting Initiative. As Congress seeks to reward hospitals that provide high-quality care, steps must also be taken to improve quality and resource efficiency in the Medicare physician payment systems. To further improve patient care,
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the Baucus plan would build on the Physician Quality Reporting Initiative (PQRI) and the provider feedback program as a next step in improving patient care.

Despite substantial concerns regarding PQRI, the program is on its way to achieving the goals set by Congress when the program was enacted in 2006: engaging clinicians and other health care stakeholders in developing meaningful quality metrics to evaluate care; putting Federal resources on the table to promote and partially fund quality improvement activities; and expediting the development of data collection processes that will lead to meaningful and actionable information flowing to providers, patients, and payers.

The first round of PQRI was executed in the second half of 2007. More than 100,000 clinicians attempted to participate in the program, and performance results and incentive payments were delivered to participants this summer. At the same time, considerable confusion lingers regarding the reporting mechanism, and reports indicate delays in the delivery of incentive payments and difficulty in accessing feedback reports.

Congress and CMS have recently acted to address these technical challenges and expand provider outreach and education programs so that the foundation of this program remains strong, and physicians are not discouraged from participating. Reforms enacted in MIPPA permit physicians to report on condition-specific groups of measures, such as those addressing diabetes and heart failure, permitting more comprehensive analysis of a physician's ability to care for patients with these chronic illnesses.

In addition, MIPPA requires the establishment of a pathway for physician groups to report quality information on an aggregated basis, reducing administrative burdens and fostering clinician-to-clinician sharing of expertise that will be much more effective in improving quality than purely governmental interventions.

Finally, Congress required CMS to expedite approval of clinical registries to which physicians report performance data. These registries, such as the National Cardiovascular Data Registry spearheaded by the American College of Cardiology, are often operated by clinician groups or medical boards and are capable of collecting richer data sets than can be accessed through claims forms. And physician recognition programs like those sponsored by NCQA are also important conduits for quality reporting. Under MIPPA, registries and recognition programs — once they are approved by CMS — will now be able to submit data to CMS on behalf of participants.

Medical boards in particular are striving to meet the professional needs of physicians while also fostering gains in quality of care. Boards such as the American Board of Internal Medicine (ABIM) are including some quality reporting in their maintenance of certification process. In order to retain ABIM certification every ten years, physicians must not only pass a traditional exam testing their knowledge, judgment, and analytical skills, but they also must participate in at least one quality reporting program. Going forward, PQRI should work in conjunction with medical boards to encourage more frequent and more aggressive recertification processes, including those that go beyond quality reporting to focus on how physicians actually perform.

Discussion Topics Regarding Health Care Reform and Board Certification

1. Do you believe the health care world in which you practice has undergone significant changes in the last 20 years?
2. Are you familiar with the Value Driven Health Care Reform that is currently taking place across the country and that is being pushed by both Republicans and Democrats?
3. Is it possible that Value Driven Healthcare may hurt the profession and practice of Optometry?
4. Do you believe the insurance companies and the government will continue to attempt to reduce the amount of reimbursement that doctors receive for the care they provide?
5. Do you believe the reduction in fees will be done based on:
 - Overall equal reduction for all providers?
 - Variable reduction based on performance and outcome criteria set by the government or insurance companies?
 - Reduction in fees based on government and insurance companies' review of your abilities and performance as a doctor?
 - Patient perceptions of your abilities as a doctor?
 - All of the above?
 - Other?
 - Fees will continually be increased equally for all doctors?
6. Are you aware that insurance companies are currently 'steering' patients to the doctors they rate as better by increasing the patient copays for the less acceptable doctors?
7. Do you believe that in the future the government and insurance companies will want evidence of the quality of services that they are paying for?
8. Do you believe patients prefer doctors that have demonstrated that they are current in their knowledge and skills?
9. Do you believe that all Optometrists who sit through the minimum CE hours required by your state for relicensure are current and competent? Do you think the government and insurance companies think all doctors who take their minimum CE hours are current and competent?
10. Do you believe it is acceptable for Optometry to be the only doctoral-level prescribing health care provider that does not have a voluntary continued competency program available?
11. Do you believe it is a disadvantage for Optometry to be the only doctoral-level prescribing health care provider which does not have a voluntary continued competency program available?

12. Do you believe a voluntary program to educate a doctor beyond entry-level competence (the competence needed to become initially licensed), would result in improved patient care, better patient outcomes of treatment and a more successful practice?
13. Continued Competence of all non-optometric doctors in the United States is measured with a Maintenance of Certification program. Are you aware that to participate in this continued competence program requires a doctor to be Board Certified?
14. Have you reviewed the Value-Driven Health Care/Board Certification presentation on the AOA Web site?
15. During the past year have you read the information on Board Certification:
 - on the AOA Web site?
 - in the *AOA News*?
 - on the AOA eNews?
 - in the *Optometry: Journal of the AOA*?
 - in other Optometric publications?
 - from information sent out by your association by email?
 - from information sent out by postal mail?
 - on online opinion blogs?
 - on the Joint Board Certification Project Team Web site?
 - attended presentations at state meetings?
 - attended presentations at society or local meetings?
16. Do you believe Optometry's future is best protected by Optometry being able to demonstrate continued competence to the government, insurers and our patients?
17. Do you believe that in the future Optometry should be a full member of the health care team with other health care professions and have a program to demonstrate continued competence similar to other doctoral-level prescribing health care professions?
18. Do you think that it is the responsibility of your elected leaders to watch the changes in the healthcare world that may affect Optometry and to recommend programs to the membership to help optometry overcome or benefit from future changes?
19. Do you think that failure to demonstrate continued competence on a test should automatically cause a doctor to lose their license as suggested by other organizations?
20. Do you think any Board Certification process and the Maintenance of Certification for Optometry program should have strong practitioner input?
21. Understanding that the Board Certification proposal is still being modified based on member recommendations and that it may be amended at the AOA House of Delegates, is it your current opinion that the AOA should participate in the proposed formation of the American Board of Optometry?