Peter H. Kehoe, O.D.
President

April 3, 2009

Dear Affiliate Association Leaders:

When the Joint Board Certification Project Team presented its draft model for board certification to the affiliate leadership in January, AOA made two commitments: we would listen to the concerns of the membership, and we would bring it to a vote in the AOA House of Delegates in June.

Beginning with that meeting -- where the project team made sure that every question was answered -- we have made every effort to listen to the concerns of AOA members and affiliate leaders. We are continuing to have questions and answers in the pages of *AOA News*, on the AOA Web site and to publish comments and letters on my blog. The AOA Board, the project team and others have made a serious effort to communicate with affiliate and regional members to continue the dialogue and to listen to all points of view.

The project team has listened to concerns and has made a number of changes to the proposed Board Certification model as a direct result of input from the members. Most prominently, we are now establishing a “board eligible” status for ODs who are qualified to take the exam but have not yet done so.

I think you will agree that we have lived up to our commitment to listen. We intend to follow through on the commitment to have a vote in June as well.

It is my hope, however, and the hope of the project team, the board, and the many others who have worked hard to create a model for board certification worthy of our great profession, that you will afford us the opportunity to present the final model before deciding how you will vote on it. We also hope those optometrists who have only heard one side of the debate, or been subjected to misinformation, will have a chance to hear more.

I know many of you are holding meetings in the next few weeks, and I am asking you to hold off making any final decision on a state position or on instructing your delegates to vote a particular way. What your members would be voting on today may well be different by the time this motion goes to the House. Please keep your options open so that your delegates can benefit from the additional information and discussions at Optometry’s Meeting®. We will continue to send you and your members material relative to this issue on a regular basis to aid in your discussions.

There is a great deal at stake for our profession. It is my hope that the deliberation will be unfettered and robust; and at the conclusion we are all able to say the profession has progressed, our members were well represented, and we have done the right thing for our profession.

I thank you for your service to our profession and our shared commitment to a stronger future.

Sincerely,

Peter H. Kehoe, O.D.

cc: AOA Board of Trustees

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243 N. Lindbergh Blvd., St. Louis, MO, 63141

Dear AOA Member:

David Cockrell, O.D.

As I meet with my colleagues throughout the United States, the topic of board certification is foremost on most ODs' minds. For me, the questions and concerns led me down the path of information gathering that I have taken in the past several months.

I wondered whether optometry really needed to be worried about changes in health care. After all, we've seen our share of the eye care market increase. Outsiders – such as U.S. News and World Report – view our profession as a very desirable one. Even the most stubborn state and federal legislators are grasping our message.

I then learned that the most recent Medicare demonstration project – called Medical Home – only accepts "board-certified" physicians (and remember we are not). And, Optometry is not specifically named a participant in the program. I started to see the writing on the wall. We have seen the increase in federal initiatives for health care reform like PQRI and P4P in the past few years. We see increased attention to health care policy changes in the White House and the federal government. Change is happening.

Just two weeks ago, while providing testimony for scope expansion legislation in South Carolina, I encountered something new to me. In their testimony, several of the MDs opposing Optometry's position referenced the fact that Optometry does not have a board certification process. It wasn't too long ago that our profession fought to use the word "physician" in Medicare. Now, it appears to me that some would seek to use yet another point (in this case, the phrase "board certification") to deny our place in health care. Change is happening **now.**

"Board certification" is shaping up to be the next barrier in our unending fight for access. The lack of it is certainly being used against us now in scope advancement efforts. As practitioners, veterans of many legislative battles *and* members of the AOA Board, we have asked ourselves, "What can we do to ensure ODs are able to overcome that barrier?"

As an AOA Board member and a private practitioner, I don't want to delay a decision simply because it is difficult to reach consensus on the issue, and then face my colleagues in the near future and have to answer, "Why didn't you try to protect our profession on this issue when we had the chance?"

As I've studied this issue, met the policymakers who make decisions that affect us, and discussed coming challenges with our colleagues from all the health care professions, I've become convinced a model such as the one proposed by the Joint Board Certification Project Team is the best next step for Optometry.

To help you learn more, we've assembled Health Care Reform, Board Certification, and Optometry's Next Step to Protect Our Future: Part One in a Series of Policy Briefings for AOA Members. It is the first in a series, summarizing what we know, and why we believe Optometry can best prepare itself for the future by moving toward a credible, defensible process of board certification. I hope you will take the time to review it, start your own course of study on the subject, and evaluate the options for our profession, now and in the future. To keep current on the latest news about health care reform, and AOA's response, visit http://certification.aoa.org, or email me at david@aoa.org.

David A. Cockrell, O.D.
Trustee, American Optometric Association
Cockrell Eyecare Center
Stillwater, Oklahoma

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243 N. Lindbergh Blvd., St. Louis, MO, 63141

Health Care Reform,
Board Certification, and
Optometry's Next Step to Protect Our Future:
Part One in a Series of Policy Briefings for AOA Members

"With health care reform moving on the fast track it is absolutely imperative for doctors of optometry to have a board certification process in place. There is interest in board certification not only from federal regulatory agencies, but also from consumers who want to be able to assess the quality of providers. The American Optometric Association and other national optometry organizations are on the right path to pursue the creation of a board certification process."

Mohammad Akhter, M.D., M.P.A.
Executive Director, National Medical Association

Critical to optometry's internal debate about how best to protect our patients' and our doctors' best interests is the need for full understanding of the powerful trends in the health care environment. These trends strongly support the need for implementation of a national board certification process along with a program for maintaining certification throughout clinical practice.

To keep our members well informed on the changing conditions of health care and the evolving model of board certification under consideration, the AOA will be issuing a series of Health Care Reform and Board Certification Briefings via direct e-mail to members and the *AOA News*.

This first briefing is on recent activity by Medicine to more tightly align board certification with national health care reform. These timely developments put further pressure on optometry to take action to protect its future.

Just this past week, the American Board of Medical Specialties (ABMS) released a statement about the role of physician standards in achieving improved health care performance and effectiveness. They called for new legislation and regulation to more directly tie board certification and Maintenance of Certification (MOC) to participation in health care and access to pay for performance. Specifically, the panelists at this event urged that board certification and Maintenance of Certification be "included in health care reform legislation as a way for patients, health insurers and policymakers to know that providers are delivering effective, quality care."

Other statements in the ABMS press release include:

- "If we are going to have meaningful health care reform, we need to have everyone on board. Now is the time to ensure that board certification is aligned with efforts to

improve quality, cost and care." -- *Janet M. Corrigan, Ph.D., MBA, president and chief executive officer of the National Quality Forum (NQF).*

- The American Board of Medical Specialties model for Maintenance of Certification "aligns perfectly with what we are doing at CMS." -- *Barry Straube, M.D., director and chief medical officer of the Centers for Medicare & Medicaid Services (CMS).*
- Dr. Straube suggested that one idea for including MOC in health care reform would be to count it as a Physician Quality Reporting Initiative (PQRI) measure. *(ABMS National Policy Forum Underscores Value of Aligning ABMS MOC with National Healthcare Policy Reform Movement, Press Release, April 8, 2009)*

Preparing for Change: Are We Ready to Protect our Scope of Practice and Physician Status?

America's health care system is in the nation's spotlight. Health care reform is at the top of the agenda in Washington and many states. Public awareness of, and interest in, the quality of care is growing dramatically as consumers demand greater transparency and accountability from the providers on whom they rely.

What's at stake is nothing less than the stature of our profession with patients, policymakers and, most important, the public and private payers who are revising how they will compensate health care providers.

Employers and other payers of health care services are moving to adopt policies to reward value and effectiveness in health care delivery. Professional societies are moving to adopt stronger standards to demonstrate initial and continuing competence in the various health disciplines. These professions are preparing for the increased scrutiny of all aspects of health care, including the status and role of health professionals in transparency and accountability of quality.

Optometry must be ready to sustain the scrutiny of health care reform and protect its future role.

Over the last three decades, the AOA and state affiliates have made impressive gains in a long-term effort to take its rightful place among the ranks of physicians. Doctors of optometry are considered "physicians" under the Medicare program. And, we are recognized as vision care professionals with a rigorous educational preparation and a scope of practice that allows us to diagnose and treat a variety of conditions and to identify markers for a wide range of systemic diseases. Optometrists' federal status as physicians brings with it the expectations of policymakers that our profession will follow the steps of other physician groups to adopt strong standards to demonstrate initial and continuing competence.

The AOA, working with other optometric organizations, believes now is the time to take the next steps to engage the profession in efforts to deepen and enrich preparation for practice and to demonstrate the continuing competence of optometrists throughout their careers in clinical practice.

The AOA is a participant in a multi-year effort (the Joint Board Certification Project Team – JBCPT) to develop a program of board certification in optometry accompanied by periodic confirmation of competence through a MOC program. The initial model was first released to the

profession in January. Based on input through the AOA national structure, many changes in the initial model have been adopted by the JBCPT. As the ABMS press release demonstrates, external events are also shaping our approach. We plan to continue seeking new information and more analysis over the next several weeks as state leaders prepare for a formal debate on the issue at the AOA House of Delegates in June.

Why Board Certification and Maintenance of Certification Now?

There are a number of compelling reasons that have led us to recommend board certification and MOC for optometry at this time. It is our obligation to prepare for the future and ensure that the practice of optometry is positioned to survive and flourish as health care continues to evolve.

- Board certification is nothing new to doctors of medicine. The American Board of Medical Specialties is now in its 75th year.[i] It assists its 24 member boards, including the American Board of Ophthalmology, in their efforts to develop and implement educational and professional standards for the evaluation and certification of physician specialists. These 24 member boards cover more than 145 medical specialties and subspecialties.

- Podiatrists, dentists, oral surgeons and chiropractors have their own certifying bodies outside of the ABMS. In the case of podiatry, there are three board certification programs under the auspices of the American Board of Podiatric Surgery, the American Board of Podiatric Orthopedics and Primary Podiatric Medicine, and the American Board of Multiple Specialties in Podiatry. Each of these boards requires certain training and experience beyond the doctoral level and requires recertification every four or 10 years.[ii] Doctors of chiropractic also have board certification options sponsored by the American Chiropractic Neurology Board, the American Chiropractic Board of Sports Physicians, and the American Chiropractic Board of Infrared Imaging. Again, each of these boards offers a certification program requiring additional formal credit hours beyond the doctoral level, experience requirements, and successful completion of written and practical examinations. One of these boards requires recertification on an annual basis while the other two do not offer a recertification process, but generally do require accredited continuing education hours to maintain certification.[iii]

- Despite longstanding board certification programs for many physician specialties, these programs have not been static but have continued to evolve, in part due to external pressures. For example, certificates originally were not time-limited. Later, many boards required periodic recertification (every six to 10 years). In 2000, the 24 member boards of the ABMS agreed to evolve their recertification model to one of continuous professional development – the ABMS MOC program. The MOC program is based on six core competencies (patient care, medical knowledge, interpersonal and communication skills, professionalism, systems-based practice, and practice-based learning and improvement). In 2006, all member boards received approval of their MOC program plans, which they are now in the process of implementing. As ABMS states, MOC "uses evidence-based guidelines and national standards and best practices in combination with customized continuing education so physicians demonstrate their leadership in the national movement for health care quality."[iv]

- Maintenance of Certification is supported by the American Medical Association, the American Hospital Association, the Federation of State Medical Boards, and the Joint Commission, among others.

- On March 26, 2009, the ABMS announced adoption of a new set of standards designed to further enhance its MOC program. This set of standards outlines and sets timelines for adopting several new MOC program elements, including:

  - Documentation that physicians are meeting continued medical education and self-assessment requirements;
  - Evidence of participation in practice-based assessment and quality improvement every two to five years;
  - Completion of a patient safety self-assessment program at least once during each MOC cycle; and
  - Assessment of communication skills using a patient survey and an approved peer survey.

These changes follow the launch of the ABMS 2008-2011 Enhanced Public Trust Initiative, which "brings an increased commitment to quality health care and transparency in physician accountability and provides the opportunity to enhance the value of MOC to the public, physicians, and the Board Enterprise (ABMS and its 24 member boards)."[v]

Lessons for Optometry

To ensure that optometry continues to enjoy the status and recognition accorded to health professionals prepared at the doctoral level and to meet the expectations of payers and our patients, optometry needs a national board certification process accessible to all optometrists. A process that only serves doctors with a specialty interest or the few percent of optometrists who have completed residences would fail to create a national program that could address health care reform. A true national system would also set the groundwork for a solution to the additional problem of state license portability.

Please watch for the next briefing on value-driven health care reform, quality measure-based pay for performance, and the evolving model for optometry's response to these trends and developments.

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[i] For additional information, visit the American Board of Medical Specialties Web site at www.abms.org.
[ii] For further details on podiatry board certification programs, visit the following Web sites: http://www.abps.org/content/members/Pathway.aspx; http://www.abpoppm.org/; or http://www.abmsp.org/.
[iii] For further details on chiropractic board certification programs, visit the following Web sites: http://www.acnb.org/; http://www.acbsp.com/certifications.htm; and http://www.accii.org/pdf%20files/Certifying_Requirements.pdf
[iv] American Board of Medical Specialties, "What Board Certification Means," Available at http://www.abms.org/About_Board_Certification/means.aspx.
[v] American Board of Medical Specialties, "New Standards Adopted to Elevate Physician Life-Long Learning Assessment for the ABMS Maintenance of Certification (MOC) Program," Press Release, March 26, 2009.

Published April 15, 2009

Dear AOA Member:

David Cockrell, O.D.

Thank you for interest and attention to my letter last week. It's my goal to personally reply to every message, and I appreciate all of you who took time to respond. From your responses last week, several important points were made. I will address some now and some in future communications.

Let me first ask you to open the links (in blue) contained in this letter. As a result of e-mails and discussions with some of you, I found that quite a few respondents did not open the links contained in that letter. Please take a look at last week's information (linked here) if you did not see it. I think you will find the information on the state of the health care reform movement very helpful. Our goal is to provide information to help you in your study of this subject. Each of these briefings, both the content of my letters and the information contained within the links, will add to the body of information that we are trying to impart.

One of my first assignments on the AOA Board of Trustees was as liaison to our Physician Quality Reporting Initiative (PQRI). As I studied the information, I learned there were many entities involved in health care reform -- many more than I had imagined. Optometry did not have a place at the table and in most cases could not make comments on the work being done, even if it directly affected our profession or patients!

The AOA Board of Trustees, through our AOA staff, began efforts to place AOA OD volunteers on those committees. In the past four years we have made significant progress and now have members on almost all of the decision-making bodies.

Our efforts have placed your fellow AOA members on the following work groups including membership in the National Quality Forum (NQF), AQA Alliance, National Committee on Quality Assurance Health Care Practitioner Advisory Council (NCQA-HCPAC) and Physician Consortium for Performance Improvement (PCPI). We are also monitoring the activities of the Quality Assurance Steering Committee (QASC). This does not mean that we can control the direction of the committees, it simply means that we are now one of many voices on the inside, and therefore, we have input. We are participating, but more important, this increased involvement gives us access to the direction that health care policy is moving. We can now be proactive instead of reactive. We can build on our success.

One of the comments I received was "How do you know this will be necessary?" In Part Two of our Series of Policy Briefings for AOA Members, you will find information on the groups I mentioned above that are involved, as well as their comments, and in some cases, recommendations. (To read it, click here.) We have worked to develop a very good working relationship with the administrators at the Centers for Medicare & Medicaid Services (CMS) and will continue to improve this relationship. In fact, we have had multiple contacts with CMS representative Tom Valuck, M.D., J.D. Since my e-mail last week, he has issued these comments:

1. The *CMS is working to enhance the value of health care services for Medicare beneficiaries in many ways, including the adoption of value-based purchasing approaches that tie measured performance to payment and transparency of health care information. We are currently working on a plan for value-based purchasing for professional services.*
2. *Public accountability for the value of services provided is a key tenet of any profession;*

professionals, including health professionals, are generally expected to develop mechanisms for public accountability. For example, health professional groups have developed quality measures, board certification for initial competency and maintenance of certification for continued competency, to demonstrate their accountability for quality.

3. *The CMS does not have a position on board certification or maintenance of certification at this time; however, some professional groups, like the American Board of Medical Specialties and the American Board of Internal Medicine have asked the CMS to consider recognizing maintenance of certification as a quality measure or quality measurement set.*
4. *Private sector payers have expressed an interest in using maintenance of certification programs for professional accountability. It is in the CMS' interest to align our payment incentive programs with similar private sector programs to maximize the impact of the incentives and reduce the burden of accountability on professionals through alignment of public payer and private payer accountability mechanisms.*

Other comments from many of you included:

- *Why will any of this apply to Optometry? It should only apply to MDs.* If the driving force behind the upcoming changes is the federal government, and they certainly are the major participant at this point, then we can expect to see change in the federal government health plans. In the case of the Medicare Statutes (1861(r)(4) we are listed in the same category as physicians. It is extremely unlikely that one provider under that classification will be held to a different standard than another. Clearly when Dr. Valuck's comments above are viewed, it is apparent that quality measures and accountability are very important to the CMS.

- *No state will make any requirements for continued competence.* We are seeing that take place currently. Colorado has recently (October, 2008) seen an announcement from DORA, the Department of Regulatory Agencies, that it intends to develop and implement a mandatory continued competence program. The administration of this program will be a function of the licensing body (DORA) for all licensees. Personally, I would prefer to have a voluntary, optometry-managed program to assure continued competence, which we can do under the proposed Board Certification and Maintenance of Certification programs, than a mandatory program that impacts my license.

I also received comments on residency requirements. Some advocated that optometry not move toward board certification until we can have residency positions for every graduate. A few stated that our process would be ridiculed by other specialties because we don't have required residencies now. Some suggest that our process will not be credible because not all ODs have completed mandatory residency programs. According to figures in the ACOE database, there are currently 294 approved residency positions distributed among the 141 programs which the ACOE accredits.

We are by no means the only profession to begin a board certification process in this manner. The last five members of the 24-member American Board of Medical Specialties to develop a board certification process began without residency programs developed and in place. They then worked to develop residency requirements for future practitioners. In fact, ophthalmology waited 41 years after beginning board certification to require residencies. I do not agree that we should make our board certification residency requirements harder to attain than medicine's.

For those of you who expressed dissatisfaction with me, or the AOA, let me point out again, we have not developed the demand for continued competence or quality measures, and certainly are not driving health care reform. Demonstrating continued competence will be an essential criterion—the price of admission—for participation in government and private insurance coverage. These events are developing rapidly from many positions, including federal and state government initiatives, as well as third-party payers and, most important, the public. Fortunately, we are participants in this process as a viable, stand- alone profession. We have the opportunity to choose how we want to participate. **Do we want the opportunity to develop our own process or do we wait and see what is developed for us?**

As a fellow practitioner, I encourage each of you to open the blue links embedded in this message and review the information. I believe you will find it informative.

Read last week's briefing here and this week's briefing here. To keep current on the latest news about health care reform, and the AOA's response, visit http://certification.aoa.org, or e-mail me at david@aoa.org.

David A. Cockrell, O.D.
Trustee, American Optometric Association
Cockrell Eyecare Center
Stillwater, Oklahoma

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243 N. Lindbergh Blvd., St. Louis, MO, 63141

Quality Improvement, Board Certification, and Protecting Optometry's Future:

Part Two in a Series of Policy Briefings for AOA Members

Introduction

For more than 100 years, the AOA has worked to serve its members' best interests. Most recently, the AOA has been seeking to be at the table in the many national forums addressing health care quality and reform. Enlightened by this frontline experience with the proponents of value-driven health care, optometry's leaders now turn to advise the profession. The AOA is working hard to keep members well-informed about the facts of the national push for quality and provider accountability.

The evidence is clear: The public recognizes the need for physicians to be accountable for the care they provide, and that quality must be defined and measured before it can be improved.

The AOA's obligation is to look forward, anticipate change and grow as a profession in order to best prepare its members to withstand the pervasive forces in mainstream health care that are currently demanding higher levels of professional accountability.

Part One of this series of Policy Briefings recognized the efforts by the American Board of Medical Specialties (ABMS) and one of its boards, the American Board of Internal Medicine (ABIM), to promote board certification as a mechanism of professional accountability and quality improvement.

In Part Two of this series, board certification is shown as the admission ticket – or "quality currency" – for the evolving health care arena of quality measurement and improvement. We show how proponents of mechanisms that adhere to continued competency and professional accountability are also the leaders of physician quality measurement and improvement initiatives.

Overview

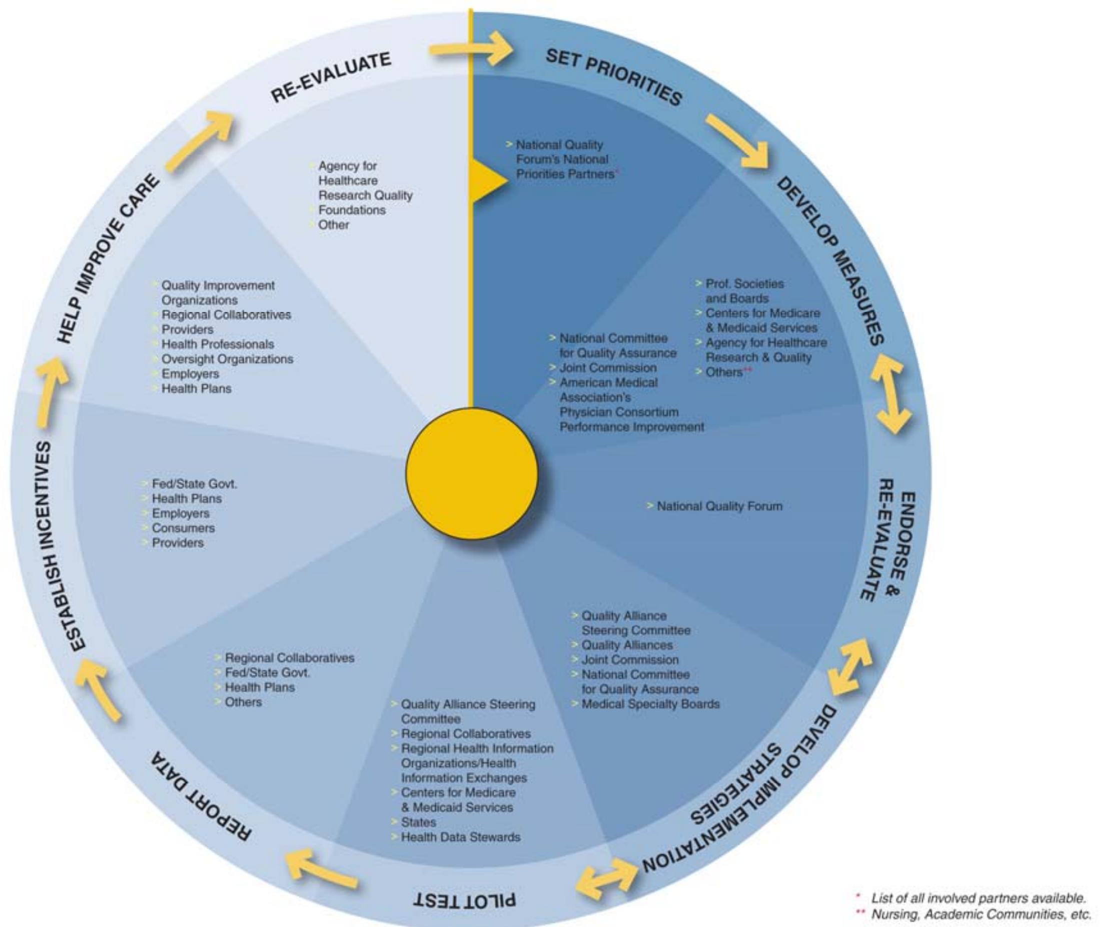
To protect our current status – as Medicare physicians – and to expand that physician status to all payer groups, optometry must use the same quality currency as medicine. Having a uniform system of board certification across all states is that quality currency.

With that currency, optometrists are able to demonstrate our national commitment to quality and public accountability. The current patchwork of state licensure standards must be bridged with a new national system of quality evidence--board certification. In turn, a national board certification system sets the stage to improve portability of licensure, a critical next step to expand the professional mobility of optometrists across the country. Currently, optometry is the only prescribing doctoral-level health care profession that does not have a process to measure continued competence beyond entry level.

Board certification is crucial to maintain equal status with other health care professions in the eye of the public and policymakers. The following individuals, and the organizations they represent, are intent on reshaping the health care system in the United States.

The AOA, in meetings and conversations, as well as ongoing research, has begun to see common themes and ideas emerge.

Multiple Stakeholders
The process of improving health care involves a complex network of multiple stakeholders and different levels of activities to advance quality and enhance value in the health care system. The following diagram from the Quality Alliance Steering Committee (QASC), a collaborative effort aimed at implementing measures to improve the quality and efficiency of health care across the United States, illustrates the process as well as the certification organizations involved.



Click HERE for a link to full-size diagram
(http://qasc.forumone.com/userfiles/Revised%20Organizational%20Wheel%202_5(7).jpg)

National Quality Forum (NQF)
The National Quality Forum (NQF) is a not-for-profit membership organization created to develop and implement a national strategy for health care quality measurement and reporting. The public-private partnership, of which the AOA is a member, plays a crucial role in quality measurement and improvement. Recently, Janet Corrigan, Ph.D., M.B.A., president and chief executive officer of the NQF, spoke out in favor of the ABMS plans for even tighter alignment of board certification and maintenance of certification with health care reform.

The NQF also has several projects that suggest an ongoing role of certification for professional accountability:

- **The National Voluntary Consensus Standards for Health Information Technology:** Structural measures related to the use of electronic health records (EHRs), electronic prescribing (e-prescribing), care management tools, and patient registries should indicate whether clinical registries analyze and report process and outcomes data that are used for maintenance of board certification.
- **Enhancing Physician Performance:** In studying the contributions of various quality improvement levers directed at physicians, including public reporting, pay for performance, board certification, internal quality improvement, and regulation, this project explores the role of the certifying boards as organizations that have effective, codified ways to both directly shape physician training and to reach into physician practice. A workshop and mini-summit this year are expected to lead to a white paper on the role of board certification in enhancing quality. This project is being funded by the ABMS.

The National Priorities Partnership (NPP)
The NQF convened the NPP, which represents consumer groups, employers, government, health plans, health care organizations, health care professionals, scientists, accrediting and certifying bodies, and quality alliances.

The partners' national priorities and goals were announced in a formal document at a public policy forum in Washington, D.C., on Nov. 17, 2008. The AOA has endorsed this document and has actively engaged in the National Quality Forum's efforts.

The partners' report titled *National Priorities and Goals: Aligning our Efforts to Transform America's Healthcare* may be found at www.nationalprioritiespartnership.org. It mentions certification as a change driver and quality measurement as a component of certification. In regards to board certification, the partners stated the following:

Board certification programs also play important roles—they provide education and assistance to health care organizations to improve performance, and they inform the public about health care professionals' competencies and performance. In carrying out these dual roles, certification programs shape professional education (e.g., residency programs that orient their training to prepare health care professionals for certification) and practices (e.g., through certification, health care professionals acquire and incorporate important skills and tools into their practices). (page 54)

National Committee for Quality Assurance (NCQA)
The NCQA seeks to transform health care quality through measurement, transparency and accountability. The NCQA's programs and services reflect the following formula for improvement: *Measure. Analyze. Improve. Repeat.* The NCQA makes this process possible in health care by developing quality standards and performance measures for a broad range of health care entities. These measures and standards are the tools that organizations and individuals can use to identify opportunities for improvement. The annual reporting of performance against such measures has become a focal point for the media, consumers, and health plans, which use these results to set their improvement agendas for the following year.

Accredited health plans today face a rigorous set of more than 60 standards and must report on their performance in more than 40 areas in order to earn the NCQA's seal of approval. Among the data collected is the percentage of board-certified physicians on their panels.

In February 2005, the NCQA and the ABIM announced an agreement giving internists seeking to maintain their certification an opportunity to more easily earn an important additional distinction: Recognition from the NCQA and its partners. Under the agreement, the ABIM, at the request of its diplomates who complete a Practice Improvement Module (PIM), will send data to the NCQA that will allow physicians to simultaneously renew their ABIM certificates and seek recognition from the NCQA. NCQA recognition qualifies physicians for many national and regional pay-for-performance efforts. The NCQA noted, "Board certification is a highly respected general credential, awarded to physicians who have met rigorous standards for intensive formal training, self-assessment, and evaluation of medical knowledge, judgment, and skills."

The Institute of Medicine (IOM) of the National Academies
In ***Crossing the Quality Chasm: A New Health System for the 21st Century*** (2001), the IOM said a challenge is to manage the growing knowledge base and ensure that all those in the health care workforce have the skills they need. "Making use of new knowledge requires that health professionals develop new skills or assume new roles. It requires that they use new tools to access and apply the expanding knowledge base. It also requires that training and ongoing licensure and certification reflect the need for lifelong learning and evaluation of competencies."

Accountability is described by the IOM as information that "should be available to assist stakeholders in making choices about providers. These stakeholders include patients identifying a clinician, hospital, or other provider from which to seek services; purchasers and health plans selecting providers to include in their health insurance networks; and quality oversight organizations making accreditation and certification decisions."[1]

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[1] **Performance Measurement: Accelerating Improvement (Pathways to Quality Health Care Series)** Committee on Redesigning Health Insurance Performance Measures, Payment, and Performance Improvement Programs, Board on Health Care Services, INSTITUTE OF MEDICINE *OF THE NATIONAL ACADEMIES,* THE NATIONAL ACADEMIES PRESS, Washington, D.C. (2006)

The Joint Commission

The Joint Commission, formerly known as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), requires its accredited hospitals to adopt and apply standards related to a physician's competence, skill, professional conduct, and ability to fulfill all of his or her professional responsibilities. Joint Commission accreditation and certification is recognized worldwide as a symbol of quality that reflects an organization's commitment to meeting performance standards and measures.

Although not required for credentialing, the Joint Commission allows hospitals to use board certification as one of its threshold criteria.[2] Board certification is "an excellent benchmark for the delineation of clinical privileges." The effectiveness of physician certification has been attributed to a relationship to other measures of physician competence. There is also evidence that better clinical outcomes are associated with board certification and continued maintenance.[3]

The Agency for Healthcare Research and Quality (AHRQ)

The AHRQ orchestrates the Consumer Assessment of Healthcare Providers and Systems (CAHPS) program to develop standardized surveys of patients' experiences with ambulatory and facility-level care. Health care organizations, public and private purchasers, consumers, and researchers use CAHPS results to improve quality of care. The CAHPS survey is the best-known instrument for measuring patient satisfaction with quality of care and outcomes of treatment. The ABMS is coordinating development of patient surveys to be used in maintenance of certification (MOC) programs and is exploring CAHPS as a tool to survey patients and to help physicians improve their practice-based care.

Centers for Medicare & Medicaid Services (CMS)

The CMS has articulated a vision for health care quality: *The right care for every person every time.* To achieve this vision, the CMS is committed to care that is safe, effective, timely, patient-centered, efficient, and equitable. Value-based purchasing (VBP), which links payment more directly to the quality of care provided, is a strategy that can help to transform the current payment system by rewarding providers for delivering high-quality, efficient clinical care. Through a number of public reporting programs, demonstration projects, pilot programs, and voluntary efforts, the CMS has launched VBP initiatives in hospitals, physician offices, nursing homes, home health services, and dialysis facilities. The CMS is working on a plan to present to Congress on value-based purchasing for professional services. Barry Straube, M.D., the CMS Chief Medical Officer, has already indicated that maintenance of certification is a potential component of VBP.

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[2] Joint Commission on Accreditation of Healthcare Organizations. Accreditation Manual for Hospitals.

[3] Brennan TA, Horwitz RI, Duffy FD, Cassel CK, Goode LD, Lipner RS. The role of physician specialty board certification status in the quality movement. JAMA. 2004;292:1038-1043.

"Public accountability for the value of services provided is a key tenet of any profession; professionals, including health professionals, are generally expected to develop mechanisms for public accountability. For example, health professional groups have developed quality measures, board certification for initial competency, and maintenance of certification for continued competency to demonstrate their accountability for quality," said Thomas B. Valuck, M.D., J.D., director, CMS Special Program Office for Value-Based Purchasing.

Dr. Valuck indicated that the CMS relies on professional organizations to define how they should be held accountable; for example, the CMS uses measures that have been developed by professional groups for the Physician Quality Reporting Initiative (PQRI).

The CMS does not have a position on board certification or maintenance of certification at this time. However, some professional groups, like the ABMS and ABIM have asked the CMS to consider recognizing maintenance of certification as a quality measure or quality measurement set. Dr. Valuck also noted in conversations with the AOA that private sector payers have expressed an interest in using maintenance of certification programs for professional accountability. The CMS is interested in aligning its payment incentive programs with similar private sector programs to maximize the impact of the incentives and reduce the burden of accountability on professionals through alignment of public payer and private payer accountability mechanisms.

New systems and the ability to meet requirements are necessary to provide safeguards on quality and address patients' and the public's concerns over the incentives for underuse that derailed the managed care movement in the 1990s.[4]

Medicare Payment Advisory Committee (MedPAC)

MedPAC, the influential advisory body to Congress on Medicare, discussed the role of board certification in its March 2005 report to Congress. "Most hospitals, health plans, the JCAHO, and the NCQA use board certification as one measure of physician quality. However, the linkage with quality is unclear. A recent systematic review found that more than half the studies of this relationship showed an association between board certification status and positive clinical outcomes." (Sharp et al. 2002)

MedPAC also noted that because so many (85 percent) physicians were board certified, the ABMS was revising its processes to better measure quality of care, including incorporating data about physician performance measures in the recertification process. MedPAC stated, "Board certification could be part of a pay-for-performance program, but the specific requirements need to be clearly linked with quality."[5]

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[4] Stuart Guterman, Karen Davis, Stephen Schoenbaum, and Anthony Shih, Using Medicare Payment Policy To Transform The Health System: A Framework For Improving Performance Health Affairs, March/April 2009; 28(2): w238-w250. (http://www.scbch.org/wp-content/uploads/using-medicare-payment-policy-to-transform-the-health-system.pdf)

[5] http://medpac.gov/publications/congressional_reports/Mar05_Ch04.pdf

In a recent paper, a team of researchers, including a former CMS administrator, a longtime MedPAC member, and a prominent health policy cost and quality expert, advocated new ways to hold providers accountable for care:

To succeed, health care reform must slow spending growth while improving quality. We propose a new approach to help achieve more integrated and efficient care by fostering local organizational accountability for quality and costs through performance measurement and "shared savings" payment reform.[6]

On March 26, 2009, the ABMS announced new standards to enhance its Maintenance of Certification program. The standards adopt several new program elements, including documentation that physicians are meeting continued medical education and self-assessment requirements; evidence of participation in practice-based assessment and quality improvement; completion of a patient safety self-assessment program; and assessment of communication skills. "Through these standards, hundreds of thousands of physicians in this country will be asked to participate in enhanced professional development activities to improve the ABMS life-long learning evaluation," said ABMS President and CEO Kevin Weiss, M.D. The ABMS quality improvement standard is:

> ***Practice-Based Assessment and Quality Improvement.*** *By 2010, ABMS Member Boards will require physician diplomates to provide evidence of participation in practice assessment and quality improvement every two to five years. With the national movement toward performance measurement, evaluation of physician activities should include evidence of practice changes to improve quality and re-evaluation to determine the effect of a change in the practice process or structure of care. Whenever possible, physicians should use nationally-approved measures such as those endorsed by the National Quality Forum (NQF).*

Lessons for Optometry

The AOA's critical efforts to position the profession of optometry to meet the powerful trends in the health care environment must address professional accountability. Quality measurement and improvement uniformly recognize the need for physicians to be accountable for the care they provide, and that quality must be defined and measured before it can be improved. Board certification and the corresponding Maintenance of Certification process will help optometrists make the case. As shown in this briefing, board certification is increasingly seen as a core requirement--the admission ticket to the new era of value-driven health care. The AOA is proactively engaging the profession to be at the table as quality improvement drives reform. For this reason, it seeks with the leadership of other optometric organizations to create a mechanism that allows optometrists to demonstrate continued competency.

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6 Elliott S. Fisher, Mark B. McClellan, John Bertko, Steven M. Lieberman, Julie J. Lee, Julie L. Lewis, and Jonathan S. Skinner, Fostering Accountable Health Care: Moving Forward In Medicare, Health Affairs, March/April 2009; 28(2): w219-w231.

Links to more information regarding organizations cited in this paper:
Quality Alliance Steering Committee (QASC) http://www.healthqualityalliance.org
National Quality Forum http://www.qualityforum.org
National Priorities Partnership http://www.nationalprioritiespartnership.org
AMA Physician Consortium for Performance Improvement (PCPI) http://www.ama-assn.org/ama/pub/physician-resources/clinical-practice-improvement/clinical-quality/physician-consortium-performance-improvement.shtml
AQA http://www.aqaalliance.com
CMS Physician Quality Reporting Initiative http://www.cms.hhs.gov/PQRI
Medicare Payment Advisory Committee (MedPAC) http://medpac.gov
National Committee for Quality Assurance (NCQA) http://www.ncqa.org
The Joint Commission (JCAHO) – http://www.jointcommission.org/

Dear AOA Member:

Joe E. Ellis, O.D.

I am currently Vice President of the American Optometric Association. I live and practice optometry in rural western Kentucky. I have been in practice for 23 years in Benton, a town with a population of 5,000 people. I acquired an existing practice and have been blessed with practice growth and a partner who has been with me for the last 10 years. I am currently on the hospital staff of the local rural hospital. I indeed face the same day-to-day challenges that you face, such as HIPAA privacy, NPI numbers, the PQRI, e-prescribing, and the implementation of electronic health records.

I decided to run for the board of the American Optometric Association in 2001 because I could envision future regulatory changes and national health care reform that could seriously supersede the premier patient access laws that we worked very hard to enact in Kentucky. The concept of value-driven health care brings to the forefront the issue of board certification/maintenance of certification, which is a major patient access issue to optometry.

As an AOA officer, I've learned a great deal about the coming changes in health care. My position can be summed up in three key ideas:

- Demonstrating continued competence will be an essential criterion – the price of admission – for participation in government and private insurance coverage.
- Optometry is the only prescribing doctoral-level health care profession that doesn't have a process to measure competence beyond entry level. Board certification is crucial to maintain equal status with other health care professions in the eyes of the public and policymakers.
- Optometry must always look forward to anticipate change and grow as a profession.

Over the past several weeks we have seen calls for individual state boards of optometry to be in charge of continued competence or maintenance of certification programs.

The idea of using state boards to prove or demonstrate continued competence won't work.

Here's why:

- First, this ties continued competence/maintenance of certification status to licensure. No other profession does that: Why would we? Why would optometry again make itself different?
- Second, state board control of the continued competence/maintenance of certification process could result in not one, but many, different processes – perhaps as many as there are licensing bodies! I think we can look at the outcome of legislation for scope advancement for proof of that statement. No two jurisdictions have the same statutory language for scope of practice; virtually no two have the same simple CE requirements. State boards develop policy in only a few ways;

through a regulatory process, like a board rule, or through statute change. In either case, the chance of getting every state and territory to use the same exact wording is nearly zero.

- Third, the composition of the boards as well as their statutory authority also will have an impact on the design and outcome of each process.

- Fourth, we know the many difficulties we now experience in reciprocity due to many reasons. Do we really want to add 50+ continued competence requirements to that list? Not only will multiple license holders be required to maintain different CE requirements – as they do now – but they will also have to keep up with multiple continued competence requirements.

- Fifth, because most boards are self-funded by licensing fees, it will be very difficult – if not impossible – to find the resources or time to develop their own process. If continued competence is left to state boards to develop and implement, we will experience a significant time delay in nationwide certification processes AND end up with a patchwork of many different types of continued competence.

- Sixth, while there is an independent board of optometry in every state, some states regulate health care professional licensing boards under an umbrella agency structure; where the umbrella agency has varying degrees of authority over the licensing boards and/or the licensees. In some states the optometry board is virtually impotent and the umbrella agency – which is staffed by non-optometrists – can wield a great deal of power over the regulation of health care providers. This may very well include the topic of continued competency assurance, as just happened in Colorado. The Colorado Department of Regulatory Agencies (DORA) adopted a policy beginning in 2008 seeking to add continued competency requirements in place of continuing education for health care professional license renewal as the various practice acts come up for sunset review. Allopathic and osteopathic medicine are excluded from complying because they have a nationally recognized board certification and maintenance of certification process. These maintenance of certification processes do not have to come only from agency mandates. Certainly legislative bodies can set parameters or requirements in statute as well.

The process that is being discussed by the AOA addresses shortcomings in the state board concept of maintenance of certification.

1. It is voluntary, not mandatory as a process linked to licensure would be.

2. It will be a national certification as opposed to the many different state or third-party mandates.

3. It will also possibly help to advance license portability – not construct even more roadblocks, as state controlled processes would.

4. Finally, I believe board certification will work to unify our profession.

If you have not seen the information contained in Dr. Cockrell's letters sent during the last two weeks, please visit *http://certification.aoa.org*.

And watch for important news from the AOA's Washington office about Congress' announcement of a plan – yesterday – to link the Physician Quality Reporting Initiative (PQRI) payments to proof of continued competence, specifically board certification.

Joe E. Ellis, O.D.
Eye Care Associates of Kentucky
Benton, Kentucky
jeellis@aoa.org

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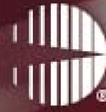
WASHINGTON OFFICE REPORT



American Optometric Association

SPECIAL EDITION: Washington Office Health Care Reform Update

Like it or not, it is clear that the Obama-led effort to transform health care in America continues to gain new momentum in Washington, D.C. And after months of buildup, key committees in the U.S. House and Senate are now on a clear pathway to mark-up legislation in the middle of June, with the goal of advancing a comprehensive plan before Congress leaves town in August.

Optometry is engaged in the process, but the challenges still to come will require optometrists from across the country to step up their involvement in what is nothing less than a fight for the profession's future.

Late yesterday, the key leaders in Congress who are drafting national health care legislation – Senators Max Baucus (D-Mont.) and Chuck Grassley (R-Iowa), the chairman and ranking member of the Senate Finance Committee – released a policy paper detailing the key elements that will be in the bill to be unveiled next month. (Full Senate Finance Paper is available here)

Relevant page of policy paper
Media coverage
Complete information on Value-Driven Health Care from the AOA

The AOA is studying the paper in detail, but already we have identified a part of the proposal that could have major implications for optometrists and other providers recognized as physicians under the Medicare program.

The Baucus-Grassley proposal would transition the Medicare's Physician Quality Reporting Initiative (PQRI) from a quality data reporting mechanism to a comprehensive value-based purchasing program to reward performance.

Under such a plan, which the AOA and health care policy experts have envisioned since 2006, PQRI participation would be linked to a physicians' participation in a qualified Maintenance of Certification (MOC) or equivalent program to show continued competency.

This is yet more evidence that, even with special interest activities increasing to a fever pitch – one estimate is that more than $1 billion has been spent in recent months on lobbying by insurance and pharmaceutical giants, hospitals and organized medicine – change will be coming to health care in the United States this year.

Since the strategic reorganization of its federal advocacy operations in 2006, the AOA has been preparing for the massive battle over what will be the most far-reaching overhaul of the health care system in American history. As a result of the reorganization, we have:

- strengthened the Federal Keyperson program

- expanded AOA-PAC
- put in place a more proactive Washington office team
- backed a host of optometry-specific bills in Congress spotlighting ODs as an access to care solution
- expanded the annual Congressional Advocacy Conference
- developed a detailed plan aimed at ensuring that the profession is prepared for changes that Congress and the president seem intent on imposing on all providers.

In short, the AOA is being heard in the nation's capital. Yet, the growing likelihood of this outcome has placed a new urgency on our efforts to be prepared for major changes coming even faster than most health policy and political experts could have predicted a year ago.

The Baucus-Grassley proposal released yesterday is the first of three sets of 'potential option' papers. The senators' primary aim is to address escalating health care costs, inefficiencies in care delivery systems and to help 47 million Americans who lack needed health care coverage. The AOA will be providing timely and detailed comments back to the full Committee to keep optometry's hard-won seat at the table.

However, even as the AOA seeks to provide input directly to the lawmakers who will soon make final decisions impacting the entire health care system for decades to come, it is important to listen and fully understand the direction in which this debate is going.

As we head deeper into the debate and the legislative process, all indications are that the president and Congress will work aggressively to impose a revised system of value-based purchasing on the Medicare program and that MOC will be an element of it. As with PQRI and HIT provider initiatives, the AOA will need to make sure that optometry is fully recognized.

However, with this change coming, optometry needs to decide now whether to be ahead of a major policy shift or at risk of having to play catch-up down the road, if that is even possible

Physician Quality Reporting Initiative (PQRI) Improvements and Requirement

Current Law

The 2006 Tax Relief and Health Care Act (TRHCA) (P.L. 109-432) required the establishment of a physician quality reporting system that would include an incentive payment, based on a percentage of the allowed Medicare charges for all such covered professional services, to eligible professionals who satisfactorily report data on quality measures. The CMS named this program the Physician Quality Reporting Initiative (PQRI). In 2008, the Medicare Improvements for Patients and Providers Act (MIPPA) made this program permanent and extended the bonuses through 2010; the incentive payment was increased from 1.5 percent in 2007 and 2008 to 2 percent in 2009 and 2010. However, no additional bonus payments were specified for the years following 2010. The following professionals are eligible to participate in PQRI: Medicare physicians, practitioners (e.g. nurse practitioners, physician assistants, clinical

psychologists), and therapists.

As directed in MIPPA, the CMS is currently developing a plan for transitioning PQRI to a value-based purchasing program that will financially reward physicians based on their performance, rather than for simply reporting quality data. CMS is required to submit the plan to Congress by May 2010.

Proposed Option:

A new PQRI participation option would be added to the existing options described above. Eligible professionals could also receive PQRI incentive payments for two successive years if, on a biennial (every two year) basis, the physician (1) participates in a qualified American Board of Medical Specialties certification, known as the Maintenance of Certification or MOC, or equivalent programs, and (2) completes a qualified MOC practice assessment.

For purposes of this proposal, the following definitions would apply:

1. Qualified American Board of Medical Specialties Maintenance of Certification (MOC) or equivalent program would mean a continuous assessment program to advance quality care and the lifelong learning and self-assessment of board-certified specialty physicians by focusing on the competencies of patient care, medical knowledge, practice-based learning, interpersonal and communication skills, professionalism and systems-based practice;

2. MOC programs or equivalent other programs must include the following assessment components:
    a. Professional standing – Programs must require physicians to maintain a valid, unrestricted medical license in at least one state or jurisdiction in the United States, its territories, or Canada.

    b. A qualified MOC program must also include a survey of patient experience with care;

    c. Lifelong learning and self-assessment – Programs must require physicians to participate in educational and self-assessment programs that require an assessment of what was learned;

    d. Demonstration of cognitive expertise – Programs must require physicians to demonstrate, through a formalized, secure examination, that they have the fundamental diagnostic skills, medical knowledge, and clinical judgment to provide quality care in their respective specialty;

    e. Practice performance assessment - A practice assessment must include an initial assessment of physician clinical quality compared to peers and national benchmarks. It also needs to include implementation of a quality improvement intervention to address an identified practice weakness, and a reassessment of performance in the area focused on for improvement; and (e) An audit process that meets standards defined by the Secretary.

3. Qualified MOC practice assessment would mean an initial assessment of a participant's practice, designed to demonstrate the physician's ability to use best evidence and

practices in comparison to peers and national benchmarks, and apply best evidence and consensus recommendations to improve quality care using follow-up assessments. Such assessment tools must:

a. Use National Quality Forum (NQF) national endorsed measures, where appropriate, to derive a set of clinical metrics that are at least equivalent in both the methods and measures used to those of the PQRI program; and

b. Require the physician to implement a quality improvement intervention to address a practice weakness identified in the performance assessment report, and then to re-measure to assess performance after this intervention.

Proposals to improve the PQRI program would require the CMS to make three additional improvements to the program.

- First, they would be required to establish an appeals process for providers who participated in the PQRI program but did not qualify for incentive payments during their performance period.

- Second, the CMS would be required to provide more timely feedback to providers during the course of the performance period.

- Third, the CMS would be required to calculate incentive payments in the PQRI program without regard to the existing geographic adjustments in the physician fee schedule since PQRI incentive payments should be based on the quality of the service performed rather than the eligible professional's geographic location.

The Committee is considering two options for extending PQRI incentive payments beyond 2010.

Option 1 would extend the 2 percent bonuses through 2011 and 2012 (for the 2010 and 2011 reporting periods). For the years 2013-2014, eligible professionals who failed to participate successfully in the program in the 2012 and 2013 reporting periods would face a 2 percent penalty, which would be calculated as 2 percent of their total allowable charges. The penalty would be assessed on an annual basis and would not be cumulative. If the Secretary determines that less than 85 percent of eligible professionals are satisfying the requirement to participate in the program, then the Secretary would increase the penalty by 1 percentage point per year (to a max of 5 percent in a single year) until 85 percent of eligible professionals enrolled in the Medicare program comply.

The second option under consideration would be identical to option 1 except that the incentive payments would only be available in 2011 (for the 2010 reporting period) and a non-compliance penalty of 1 percent would begin in 2012 (for the 2011 reporting period) The penalties for non-compliance in 2012 and 2013 for the previous year's reporting period would remain at 2 percent, and the requirement that the Secretary increase the penalty (by 1 percentage point per year up to a 5 percent cap until 85 percent of practitioners meet the requirement) would be the same.

Pete Kehoe, O.D.
President

April 29, 2009

Dear State Leader:

Several weeks ago, in light of fast-moving changes in health care reform and the AOA seeking time to listen — and respond to — member comments and concerns about board certification, I asked you to hold off making any final decision on a state position or on instructing your delegates to vote a particular way.

I have appreciated the response to that e-mail, and absolutely respect all the state and affiliated optometric associations' desire to act in accordance with their best judgment. Regardless of where your state stands, I thought you would welcome an update on the process, and on the latest news from Washington, D.C., that we feel underscores the importance, and timeliness, of AOA's board certification proposal.

First of all, I want to make you aware that AOA has stayed true to its promise to listen to its members and represent the profession. As you may recall, the Joint Board Certification Project Team (JBCPT) made several changes in March to the initial proposal, including adding a "board eligible" classification and changing the composition of the proposed American Board of Optometry to ensure better representation of practicing ODs. Both of these changes were a direct result of constructive input from our members.

I'm pleased to report that the JBCPT is holding another meeting via WebEx on May 4 and the AOA representatives will offer a number of substantial proposals for revision. As we did in March, we will raise multiple issues — as they were presented to AOA leadership — in the hopes that the model is strengthened and the end result is one that we can all accept.

We want you to be the first to hear the outcome of the JBCPT meeting. We have arranged a WebEx conference on May 5 just for state leaders. Details are at the bottom of this email, but the key point is this: It is vitally important to the profession that the leaders of optometry have a clear understanding of what is being proposed and the rationale behind it. Please make every effort to participate.

For those of you who have yet to hold your state or affiliate meetings, let me restate what I said in my previous letter: It is my hope, and the hope of the project team, the board, and the many others who have worked hard to create a model for board certification/maintenance of certification worthy of our great profession, that you will afford us the opportunity to present the final model before deciding how you will vote on it. We also hope those optometrists who have only heard one side of the debate, or been subjected to misinformation, will have a chance to hear more.

Earlier I mentioned that health care reform is moving fast. Just last night we got word of the following:

The Senate Finance Committee released a new policy paper outlining their reform agenda. The American Board of Medical Specialties was successful in convincing the committee to align board certification with Physician Quality Reporting Initiative (PQRI). Here is an excerpt from page 6 of the report. ***A new PQRI participation option would be added to the existing options described above. Eligible professionals could also receive PQRI incentive payments for two successive years if, on a biennial (every two year) basis, the physician (1) participates in a qualified American Board of Medical Specialties certification, known as the Maintenance of Certification or MOC, or equivalent programs, and (2) completes a qualified MOC practice assessment.***

It is clear that our profession needs to be informed, prepared and united. Please join us for the WebEx conference, visit http://certification.aoa.org for more information, and stay tuned.

I thank you for your service to our profession and our shared commitment to a stronger future.

Please feel free to contact me or your liaison trustee with comments, concerns or questions.

Sincerely,

Pete

President, American Optometric Association
Kehoe Eyecare
Galesburg, Ill.

Conference Details

We are inviting you to participate in a WebEx conference on Tuesday, May 5, at 9 p.m. Eastern Time (8 p.m. CDT) to review this revised working outline so that you may in turn present this to your members. Log-in and call-in instructions are listed below.

Topic: Board Certification Briefing/Update
Date: Tuesday, May 5, 2009
Time: 8:00 pm, Central Daylight Time (Chicago, GMT-05:00)
Session number: 573 778 904
Session password: 123456

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1. Go to https://aoa.webex.com/aoa/k2/j.php?ED=122817782&UID=1062158087&RT=MiM3
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