Final Report of the 2013 National Optometric Continuing Education Conference

April 27-28, 2013

Hilton Hotel
Rosemont, Illinois
2013 National Optometric Continuing Education Conference Final Report

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Forward

The 2013 National Optometric Continuing Education Conference (NOCEC) was held April 27-28, 2013 at the Hilton Hotel in Rosemont, Illinois. Participants represented eighteen optometric organizations, fifteen licensing boards of optometry, nine schools of optometry, and four companies within the ophthalmic industry.

Introduction

The face of continuing education has changed significantly since the last continuing education conference in 2006. One major outcome of the last conference was the implementation of the Standards for Commercial Support by the Council on Optometric Practitioner Education (COPE). Continued changes in technology and educational methods, new uses for continuing education, and the demand from the public for assurance of continued competence compelled ARBO to bring representatives of the optometric profession and industry together for another conference.

The 2013 NOCEC had several purposes: First, to elicit input into the changing direction of COPE as directed by a resolution at the 2012 ARBO Annual Meeting which mandated that COPE implement alternative methods of accrediting continuing education similar to those used by other organizations and professions such as the ACCME. Secondly, the NOCEC participants were asked to assess the current status of continuing education within the profession of Optometry and to discuss new uses of accredited CE to support programs such as Board Certification and Maintenance of Certification which have been created since the last NOCEC. Finally, the group was asked to develop ideas and implementation strategies for the future of CE.

This report is a summary of the discussions and recommendations made at the conclusion of the conference. Great effort has been made to ensure that this record is accurate and clearly expresses the intent and opinions of the participants. This report incorporates keynote presentations, panel discussions, and the results of breakout sessions. Individual position papers submitted by several of the participant organizations prior to the conference have also been included. The report should not be viewed as an official statement of policy represented or recommendations by any group or individual in attendance. There is no implied endorsement of the materials presented by any organization or individuals.

Mission Statement

The Mission of the 2013 National Optometric Continuing Education Conference is:
“Supporting improvement in knowledge, performance and patient outcomes for the public welfare.”

The Association of Regulatory Boards of Optometry conceived and hosted the NOCEC. The NOCEC committee was co-chaired by Dr. Jerry Richt and Dr. Ernest Schlabach. The NOCEC task force members included Dr. Donovan Crouch, Dr. Steven Eyler, Dr. Jill Martinson-Redekopp, Dr. Gregory Moore, Dr. Michael O’Hara, Dr. Roger Pabst, Dr. William Rafferty, Dr. Robert Smalling, Dr. Christina Sorenson, Dr. Susy Yu, and Dr. Michael Ohlson. The NOCEC staff consisted of Ms. Lisa Fennell and Ms. Sierra Rice. The complete attendee list can be found in Appendix A.
Executive Summary

Regulatory pressures are driving health care providers to measure competencies based on performance outcomes. Optometry is no exception. ARBO, representing member boards, has fiduciary responsibility to ensure that continuing education, required for maintenance of licensure, is effective in improving knowledge, performance, and patient outcomes. Maintenance of certification, insurers, employers, and other organizations also rely on CE as a measure of qualification or competency. Therefore, COPE must continually improve its accreditation process and criteria, so that optometric CE meets the expectations of its constituents.

General Recommendations from this meeting:

- Expand COPE from only activity accreditation to include provider accreditation as an option.
- Develop more effective tools for needs assessment and self-assessment.
- Define and incorporate appropriate outcomes measurement in the CE planning and delivery process.
- Change the definition of 1 CE hour to 1 CE hour unit, with defined equivalencies for each hour unit or fraction thereof.
- Develop criteria for COPE which allows for equivalence with other healthcare professions leading towards inter-professional accreditation in the future.

Proceedings

The conference opened with three keynote speakers. Lawrence Sherman gave a presentation titled, “Continuing Education: A Provider’s Guide to the Universe”; Dr. Murray Kopelow gave a presentation titled, “Why Provider Accreditation?” and Dr. Donald Moore gave a presentation titled, “The Future of Learning in the Professions: Outcomes-Based Education and Principles to Help People Learn.” The handout materials from these presentations are included in Appendix B.

Three separate panels discussed continuing education accreditation in other health professions, industry compliance in support of continuing education, and continuing professional development in the era of health care reform. The handout materials from these presentations are included in Appendix C.

Following the presentations, attendees were divided into three workgroups and assigned a primary topic of discussion (Appendix D). These organized breakout groups met in two sessions over a two day period. Prior to adjournment each workgroup submitted a record of their discussions and their recommendations and conclusions.

Position Papers

Position papers were requested from several of the organizations that participated prior to the conference. Each organization was asked to describe their perspective on improving knowledge, performance, and patient outcomes in optometric continuing education. The position papers are included in Appendix F.
Breakout Group Discussions

A complete record of the notes taken during the breakout group discussions is included in Appendix E. To insure accuracy, the notes in the appendix are largely unedited by the authors of this report (multiple statements of the same concepts have been deleted, and some wording edited for clarity). Although abbreviated at times, this information should be considered as valuable “raw data” for future analysis. The attendees assigned to each breakout group can be found in Appendix D. For purposes of this report, the term “CE” shall be used to refer to optometric continuing education regardless of the form it might take. The term “provider” refers to an organization or business that offers courses or other forms of continuing education for optometrists. The term “activity” refers to individual CE events. The terms “speaker” or “presenter” refer to those actually teaching and/or writing the course. “Participants” are those optometrists who engage in the various courses and other professional development activities.

Conclusions of the Workgroups

After analysis and discussion of the assigned topics, each work group developed and reported their recommendations. Again, there is no implied endorsement of these recommendations by any organization or group in attendance. These statements do not reflect the policy of any organization that was represented or the corporation who supported the conference.

Conclusions on the Topic of CE Planning and Outcomes
(Breakout Group A)

The group concluded that optometry should have more effective tools for needs assessment and self-assessment which could take the form of a robust SAM (Self-Assessment Module). This would be an evidence-based system with width and depth in various subject areas. COPE and the profession should develop a dynamic list of expected competencies for the SAM tool that take into consideration the different modes of optometric practice, as well as the common competencies that all practitioners should share. It is important that barriers to using the SAM tool be addressed. One way to do so would be to reduce cost and increase return for doing self-assessment modules (i.e. allow increased CE credit as compared to an ordinary course). Assessment should be considered to be validation and/or practice development and not just a “test” or a hurdle for the practitioner to pass. This change in attitude will no doubt be gradual, and assessments may have to be voluntary to begin with for it to occur. The ultimate goal should be a form of self-assessment that can help identify deficiencies but also provide a means for remediation (perhaps by suggesting guided learning through specific courses and workshops).

A standardized mechanism is needed to help determine the objectives of a CE course and to insure that they are met. (There should also be a template that speakers can use to insure that course objectives are met; in other words, a form of outcomes measurement for speakers as well as for those who might take a course. Participant reviews of courses could be used as part of these measurements.) CE providers should have a standard “best practices” template for evaluation forms and similar documents. When assessments are required, there should be a template for the assessment questions similar to those that the NBEO uses for its examinations. It is important that those taking the assessments be given feedback as to WHAT was missed and
not just the number of questions or a final score as is most often the case currently. The group discussed whether the requirements for CE should be “specialized” according to the type of practice of the provider. It was agreed that there must be a minimum competency set for safe practice, and then allowance for education in specialty areas.

Continuing Education speakers and providers should be better trained on course formulation and presentation. Templates for outline formulation should be provided. It was suggested that COPE consider providing an online course for CE speakers/providers, similar to the training given to COPE Reviewers. Speaker training could be a requirement for provider accreditation. The provider would accredit their own speakers but would use pre-set tools and templates provided by COPE. The group also discussed inter-professional relations, and how differences in our clinical language might hinder these. It was agreed that we should try to encourage the development of CE that can be used by several different types of providers or professions. Attendance at these events could be very beneficial and educational for the providers, as it gives them the added value of learning more about how they to best interact with other professions in the health care delivery system.

The group felt that it was important to consider the value of implementing change in practice as a result of an educational activity. Using a remote post-test could be considered in addition to an immediate test as part of outcomes assessment. This should be tied to the educational credits awarded. In other words, if the CE participant still retains and uses information from the course six or eight weeks later they might receive additional credit.

The need to embrace technology/social media without allowing it to avoid interaction with others was a concern of the group. It is important to insure that participants do not simply self-select only the courses they enjoy listening to (as opposed to those in subject areas where they might be deficient). If participants engage in online learning more often, there should be a careful monitoring by regulatory agencies of the course content to insure it is of sufficient breadth and variety. Changes in technology will undoubtedly lead to new ways to participate in continuing education. CE must also be better adjusted to different learning styles. Social media can be used to give providers feedback, but perhaps also as a CE tool itself (through participation in chat groups/blogs, etc.). Technology can also help to meet outcomes goals on a long-term basis, with periodic reminders as to objectives, feedback surveys, etc.

The group agreed that COPE will need a consistent way to determine CE equivalency of hours to meet state board needs and legal requirements. The concept of “COPE hours” was discussed. These could be used to determine equivalency standards for the different modes of delivery. It was suggested that collaboration with other professions on this issue may be helpful in developing the equivalency concept. The Federation of Associations of Regulatory Boards (FARB) would be a good resource for these discussions. Assessments could be used to help determine equivalencies as well. Perhaps added credit value could be tied to the use of the assessment and completion of the plan determined after the assessment. The assessment could be used as a multiplier for credit (i.e. utilize it and you get 1.25X the credit). Discussions of EBM (Evidence-Based Medicine) surrounding the activity subject could serve as an additional multiplier. The group recognizes that both CE providers and regulators will need to be flexible in the adaptation of new technologies to the delivery of education.
Conclusions on the Topic of Provider vs. Activity Accreditation  
(Breakout Group B)

The group supported the concept of provider-level accreditation for CE, and concluded that ideally all optometric CE providers would strive to become accredited at the organizational level. Participants acknowledged that accrediting at an activity level may be more advantageous for emerging providers, as it would provide more immediate feedback and training for one who is new to the accreditation process. Accréditing at the activity level may also benefit smaller state or provincial associations or local societies that lack the resources needed to accredit at the organizational level. COPE should investigate avenues where larger providers could assist in accrediting CE for local optometric societies or smaller organizations if necessary.

The group concurred that although there is greater freedom and potential for creative CE initiatives within a provider model it also requires greater accountability on the part of the providers. Although the provider accreditation model initially is more labor intensive for CE providers, it also may have greater value to the providers, the profession and the public. The anticipated benefits would include organizational improvement, outcome-measured CE as well as CE designed to address specific practice gaps of the learner. Outcome measured CE will advance the goals of improved knowledge, performance and patient outcomes.

The group stressed the importance of significant outreach to the optometric community as the changes in CE accreditation proceed. Significant resources will have to be allocated to training providers in the new accreditation process. Confusion exists regarding the concept of determining practice gaps and defining expected outcomes in the educational planning process. Implementing formal quality improvement processes (QI) will be a new process and this concept must be addressed so that the providers understand how best to implement QI.

Expediency in completion of the model should not take precedence over the validity of the final product. In focusing on outcome based CE, great thought needs to be put into the actual criteria. Those who develop the criteria and implementation tools should be cautioned to avoid strict formularies that would stifle the creativity of the Providers. The final product must emphasize the outcomes of the educational activities.

Although a lexicon aligned with other CE accreditors’ glossaries is helpful, a change in the definition of continuing education (CE) is not advised at this time. Efforts to change CE terminology should only be considered after careful analysis of future implications. Changing terminology may be a long term goal for regulatory boards. Considering the financial and logistical resources, this may be more feasible to accomplish through the rule-making process.

Significant progress is being made in the presentation of independent optometric continuing education. Some providers are increasing their scrutiny of the final course presentation and have implemented more stringent review of outlines and PowerPoint presentations seeking to assure courses are presented in an unbiased manner. Some providers are implementing tools which they hope will adequately address conflicts of interest at the level of the planning committee. A provider model of accreditation could shed further light on the extent to which all providers are complying with the COPE Standards for Commercial Support.
Conclusions on the Topic of Future Deliveries of CE  
(Breakout Group C)

The group discussed the need to develop an appropriate unit of equivalency that can be used for alternative learning methods. They suggested that perhaps COPE use the term “COPE hour unit” rather than “hours” in determining course credit. The group recommended that determination of this unit value be based on existing adult learning theory. Educational institutions often talk about an EVU (Educational Value Unit) and this concept could be used in the determination. EVUs include definitions of equivalency for 1 CE hour and would offer flexibility to allow for smaller increments of time and recognize the value of interactivity or delivery formats. An incremental approach to this change might be in order. The group also discussed how best to require demonstration that the learning activity was effective, since the amount of actual learning that takes place is so individual. CE development should always incorporate theories of adult learning. The participants should learn what they want and what they need to know in a manner that is relevant to them as individuals.

The group also discussed changing the presentation of the CE so that individuals can measure their own learning outcomes. One example of how to do this would be asking the participants to take an anonymous assessment prior to the presentation and then compare their results with a post test. This may be separate from measuring the effectiveness of the CE itself.

The group acknowledged that online and distance learning formats may not be widely utilized due to variations in state/provincial law and regulations. There should be a move towards attempting to accept as wide a variety of learning formats as is practical on a jurisdiction by jurisdiction basis. Each jurisdiction should also consider requiring that some portion of CE requirements include outcomes-based criteria. COPE might also consider requiring accredited providers to include this as some portion of their CE inventory. It is important to understand that CE can be used for both maintenance of licensure and to improve competency and clinical outcomes. Finally, the group recommended that the profession and COPE recognize and encourage the effort to expand intra-professional continuing education.

Final Observations and Summations

The 2013 NOCEC provided an excellent opportunity for all stakeholders to discuss the manner in which optometric continuing education must evolve to stay relevant to the needs and wants of practitioners and to be equivalent with other healthcare professions. The conference was well attended by a broad representation of stakeholders within the optometric profession. The meeting was considered a success in that all stakeholder groups were collaboratively engaged in the process of fulfilling the stated mission of the conference.

Some of the specific outcomes of the meeting were: known gaps in the current accreditation system were socialized by COPE; new gaps were identified by the attendees; solutions were synthesized; and consensus was achieved in many areas. Interestingly, the topics of discussion for the three breakout groups were all different, yet there were certain themes and areas of interest common to all three. These included the need to modernize the delivery system to reflect changes in technology (i.e. online learning), the concept of provider accreditation for continuing education (as opposed to individual course/event accreditation), the need to measure
outcomes to better determine the effectiveness of the education, and a recommendation to participate with other healthcare professions in inter-professional accreditation.

Although a hybrid accreditation model is being considered by COPE, both the provider accreditation path and the per-activity accreditation path, should incorporate similar criteria that encourage the implementation of an ongoing self-evaluation Quality Improvement process, particularly with regard to establishing expected outcomes for a given activity and the assessment and validation of these outcomes. Expansion of system-wide data collection, including outcomes, is essential to the validation of any accreditation model. New accreditation criteria should also enable innovation in education, and encourage interactions within the “community of CE providers” particularly in the area of inter-professional or “team based” care. Given the expectations of an increasingly demanding society, the expanding knowledge base of optometry, and the changing learning patterns and demographics of the newest generation of learners, it’s crucial that COPE and the State Boards of Optometry evolve to support formats other than the traditional heavily monitored didactic approach.

Continuing education in optometry serves many purposes (maintenance of licensure, board certification, maintenance of certification, etc.), all of which must be considered as new criteria are developed for CE delivery and accreditation. The primary purpose of CE is fostering public health, but the needs of practitioners and CE providers must also be considered. It is also important to remember that CE is a legislative requirement in all the jurisdictions that ARBO represents, and the specific requirements of those regulatory bodies must continue to be addressed. Optometric continuing education must strive to go above and beyond minimal legislative standards that are largely designed to protect the public through the doctrine of “do no harm.” Truly effective CE will incorporate a variety of delivery systems and assessments to provide the participants with a positive experience that encourages them to reach their full potential as practitioners.

The recommendations and discussions contained within this report should guide COPE in its ongoing mission to improve both CE accreditation and outcomes. It is the sincere hope of the conference committee that this is just the beginning of an ongoing conversation on the future of optometric continuing education. Going forward, based on the successful collaborative format of this meeting, COPE has created a permanent Intra-professional Advisory Board to COPE. Core group invitations have been extended and can be expanded as needed in the future.
APPENDICES

APPENDIX A
Attendee List

APPENDIX B
Keynote Speakers

APPENDIX C
Panels

APPENDIX D
Work Groups

APPENDIX E
Breakout Group Notes

APPENDIX F
Position Papers
## Appendix A: Attendee List

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<td>Theresa Jowell</td>
<td>Head, Research and Education Grants Group Alcon Laboratories</td>
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| Murray Kopelow, MD, MS(Comm), FRCPC | President and Chief Executive Officer  
Accreditation Council on Continuing Medical Education (ACCME) |
| Jill Martinson-Redekopp, OD | COPE Committee Chair  
Vice-President, North Dakota Board of Optometry  
Director, National Board of Examiners in Optometry |
| Donald Moore, PhD     | Director Program Evaluation, Office of Teaching  
and Learning in Medicine  
Director, Division of Continuing Education,  
Vanderbilt University School of Medicine |
| Gregory Moore, OD     | Director, Association of Regulatory Boards of Optometry  
Secretary-Treasurer, West Virginia Board of Optometry  
Optometric Competence Committee Member |
| Kenneth Myers, OD     | President, American Board of Certification in Medical Optometry  
Director Emeritus, VA Optometry Service |
| Michael O’Hara, JD, PhD | Director, Association of Regulatory Boards of Optometry  
Secretary, Nebraska Board of Optometry |
| Michael Ohlson, OD    | President, Association of Regulatory Boards of Optometry |
| Jeanne Oliver         | Director of External Relations, Pacific University |
| Dominick Opitz, OD    | Director, Continuing Education, Illinois College of Optometry |
| Roger Pabst, OD       | Vice-President, Association of Regulatory Boards of Optometry  
President, Minnesota Board of Optometry |
<table>
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</table>
| Melissa Padilla               | Director of Professional Studies & International Programs  
Pennsylvania College of Optometry at Salus University |
| Nancy Peterson-Klein, OD      | President, National Board of Examiners in Optometry  
Board Member, Michigan Board of Optometry |
| Christopher Quinn, OD         | Trustee, American Optometric Association                                                      |
| William Rafferty, OD          | Director/Past President, Association of Regulatory Boards of Optometry  
Chair, Optometric Competence Committee  
Director, National Board of Examiners in Optometry |
| Bruce Rakusin, OD             | Committee Member, COPE Committee  
Chairman, Massachusetts Board of Registration in Optometry                                      |
| Kate Regnier, MA, MBA         | Deputy Chief Executive & Chief Operating Officer Accreditation Council on Continuing Medical Education |
| Sierra Rice                   | Program Coordinator, Association of Regulatory Boards of Optometry                           |
| Jerry Richt, OD               | Immediate Past President, Association of Regulatory Boards of Optometry                      |
| David Rybak                   | Franchise Health Care Compliance Officer  
Johnson & Johnson Vision Care                                                                  |
<p>| W. Ernest Schlabach, OD       | Secretary-Treasurer, Association of Regulatory Boards of Optometry                           |
| Lawrence Sherman              | Senior Vice President, Prova Education                                                        |
| Robin Simpson, OD             | Registrar, College of Optometrists of British Columbia                                        |
| Robert Smalling, OD           | Committee Member, COPE                                                                      |</p>
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<tr>
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<td>Christina Sorenson, OD</td>
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<td>Elizabeth Taylor</td>
<td>Executive Director, SECO International</td>
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<tr>
<td>Dimitra Travlos, PharmD, BCPS</td>
<td>Assistant Executive Director &amp; Director CPE Provider Accreditation, Accreditation Council for Pharmacy Education</td>
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<td>Associate Dean, Ohio State University College of</td>
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<td>Immediate Past President, American Academy of Optometry</td>
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APPENDIX B

KEYNOTE SPEAKERS

Continuing Education: A Provider’s Guide to the Universe ........................................... p. 19
Lawrence Sherman, FACEHP, CCMEP, Senior Vice President, Prova Education

Why Provider Accreditation? ............................................................................................................... p. 24
Murray Kopelow, MD, MS (Comm), FRCPC, President and Chief Executive Officer,
Accreditation Council on Continuing Medical Education (ACCME)

The Future of Learning in the Professions: Outcomes-Based Education and Principles to Help People Learn ................................................. p. 29
Donald Moore, PhD, Director, Program Evaluation, Office of Teaching and Learning in Medicine, Director, Division of Continuing Medical Education, Vanderbilt University School of Medicine
Continuing Education in Healthcare: A Providers’ Guide to the Universe

ARBO
National Optometric Continuing Education Conference
Rosemont, IL
April 27th, 2013

Where to begin?
Who am I?
Who are you?
What would you like me to talk about in the next 40 minutes?
What were you expecting when you saw the title of my presentation?

By knowing what you want...
...we know where we need to wind up.

Remember this:
You cannot measure it if you cannot measure it.

My Proposition
• A walk through the provider’s journey making stops at
  • Understanding the learners’ needs
  • Designing appropriate education
  • Evaluation ever so briefly
  • Accreditation even more briefly

The Journey Begins
With the End in Mind
• CE begins the same way that this session started
The Journey Begins
With the End in Mind

- CE begins the same way that this session started

By understanding the audience and their needs

We Would Never

- Develop CE activities without assessing the needs of the learners
- Base the content of CE activities on the opinion of just one person
- Assume that all learners have the same needs
- Homogeneous audiences have heterogeneous needs, preferences and learning styles
- Develop education that is not independent and transparent

We Follow Best Practices in Educational Needs Assessment

- What are they?

We Follow Best Practices in Educational Needs Assessment

- Learner survey data
- Direct interaction with learners
- Evaluation data from past activities
- Literature review
- Expert interview
- Practice guidelines, etc.

But also

Other Information Is Important

- Learning style preferences
- Learning format preferences
- Environmental scan
- Who should teach?
- Who shouldn’t teach?

Why is this Important?
Why is this Important?

Right education = Right learner + Right content + Right objectives + Right format + Right time...

That Begr the Question: Which Format is Best?

That Begr the Question: Which Format is Best?

- There is no easy answer
- Varies based on
  - Personal preference
  - Opportunity
  - Where and when the needs arise
  - Where the learners are already looking?
  - Etc.

We Would Never

- Develop education that isn’t relevant to the practice setting and needs of the learners
- Deliver education in formats that are not appropriate for the content to be presented
- Provide education that really isn’t education
- Base education on learning objectives that are not ultimately measurable

What Do You Think of These Learning Objectives?

We Follow Best Practices in Educational Design

- Right venue
- What works in live education?
- Right platform
- What works in digital delivery?
- Right duration
- How long is too long?
- Right faculty
- Learner engagement
- Measurement throughout
What Are Your Best Practices?

- Are you maximizing the venues and platforms?
- Are you validating needs of the learners present?
- Are you using adult educational theory and practice?
- Are you involving the learners?
- Are you using technology and social media?
- Are you creating a framework for learners to create personal learning networks?
- What else?

How Are You Evaluating Your Educational Activities?

- What are you trying to measure?
- What constitutes success?
- What methods can you use?

We Would Never

- Measure at too low a level
- Measure at too high a level
- Not measure at all

We Follow Best Practices in Educational Evaluation

- I will leave this to Don...

A Word or Two on Accreditation

- Accreditation matters
We Would Never
- Certify or accredit education that doesn’t meet our own minimum standards of appropriate.

I’ll Let Murray Talk More About Accreditation

Questions?

Thank You
Murray Kopelow, MD, MS (Comm), FRCPC

CME as a Bridge to Quality

Why Provider Accreditation?

APRIL 2013

My Perspective

<table>
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<th>Activities</th>
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<td>132,768</td>
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2011 Reporting Year

Physician Participants: 13,741,621
Non-Physician Participants: 9,558,789

ACME Accredited n = 487
Society Accredited n = 8,382

Provider Accreditation
Is it Best? ....it depends

Accreditation is a process based on standards by which institutions or organizations receive approval to act

The standards of accreditation describe and assess if an organization:
1. Knows what to do
2. Can do it
3. Does it consistently

Depends a lot on the Facts and Circumstances

Some people would say...
Activity accreditation is efficient with smaller numbers, often found in an emerging or developing system.
Provider accreditation can leverage organizational evolution and sophistication - of providers - as a tool to attain and maintain standards.

CPD System’s Stage of ‘Development’
Economies of Scale and Scope

Do you want to take advantage of economies of scale and scope for the benefit of organizations doing many activities?

How much work is it?

1. The amount of energy spent by,
   PROVIDER
   - Develop their PROGRAM
   - Ensure an activity is in compliance
   - Prepare and submit their WHOLE PROGRAM for accreditation (independent of # activities developed)
   - Prepare and submit an activity for accreditation (independent of # activities developed)
   Accreditor to:
   - Ensure a whole program is in compliance (independent of # activities reviewed)
   - Ensure an activity is in compliance

2. The total number of activities a provider develops

3. The number of activities reviewed by a provider accreditation.

How much work is it in activity accreditation?

1. The amount of energy spent by,
   PROVIDER
   - Develop their PROGRAM
   - Ensure an activity is in compliance
   - Prepare and submit their WHOLE PROGRAM for accreditation (independent of # activities developed)
   - Prepare and submit an activity for accreditation (independent of # activities developed)
   Accreditor to:
   - Ensure a whole program is in compliance (independent of # activities reviewed)
   - Ensure an activity is in compliance

2. The total number of activities a provider develops

3. The number of activities reviewed by a provider accreditation.

Energy Cost: Comparison Between Activity and Provider Accreditation

Business Efficiency and Effectiveness

Do you have the human and financial resources to work in an inefficient space?
Amplification Effect
Do you want to take advantage of the amplification effect of provider accreditation? ... where one 'accreditation decision' can turn into,

100's of directly sponsored activities
several organizations doing CME through co-sponsorship, co-development or mentoring

- Accreditation becomes empowering rather than constraining.
- Organizations can mentor other organizations through review of their work, working together to design and develop educational resources for learners.

<table>
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<td># Activities in system</td>
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</table>

Depends a lot on the Facts and Circumstances
Activity accreditation efficient with smaller numbers often found in an emerging or developing system.
Provider accreditation leverages organizational evolution and sophistication — of providers - as a tool to attain and maintain standards.

CPD System's Stage of 'Development'
Ressources Necessary: Become Enormous

Creating a Community of Practice

Issues to Consider
Is the goal to develop and implement a system through the intentional collaboration among CPD organizations?
- Provider accreditation creates an identifiable 'membership'
- Membership is fostered by a shared set of values, principles and aspirations

Agreement with a common set of values and principles encourages engagement in the accreditation process.
The community becomes the vehicle to implement and advocate for future improvements to standards and practices - continually raise the bar!

Communication Channels

Issues to Consider
How can you best communicate the principles, values and metrics embedded within the standards?
- Communication channels with "members" enables you to identify those who are actively engaged in developing CME in compliance with established requirements.

Promotes the sharing of innovations and practices in education, administration and evaluation between providers.
Enables multiple channels of communication to institutions and organizations outside the accreditation system.
Organizational Development

Issues to Consider
Do you want an accreditation system that contributes to organizational development?

- Do you want change agents or accredited activities?

Organizational Development particularly important in promoting the interpretation and application of standards that requires judgment and decision making skills.

Judgments are reflected by "the accredited provider community" – their practices illustrate how it can be done.

System as a Participant

Issues to Consider
Do you want your accreditation system to participate in the national and international movements to healthcare quality improvement?

- CPD provider accreditation systems can influence and contribute to quality care through the application of educational standards.

CPD Systems
- Can influence and relate to other systems.
- Have the opportunity to integrate with and be relevant to the broader health care system.
- A system that influences care requires partnerships; that include multiple types of organizations.

Systems Evolve and Change

Do you want to improve your accreditation decision-making process, and the system, itself?

Provider accreditation changes,
- Adaptive 1st order changes
- Evolutionary 2nd order changes

...the system itself is changed

Examples: the ACCME's addition of the identification and resolution of conflict of interest or engagement criteria have few if any measurable manifestations in an activity.

Data, education, innovation and research is fostered through systems.

The organizations that work within these systems are both the recipients of the innovation of others and contribute their own innovations to the benefit of others.

Organizations improve at a faster rate when they share and collaborate than when they work in relative isolation.

CME providers as an “Academy”

Do you want to promote the community of CME providers as an “Academy” where CPD and CME is viewed and promoted as scholarly pursuits?

CPD like clinical research... CME like the lab has a greater opportunity in a CPD Provider model because...

- Systems can contribute to, or at least reflect, the scholarship and research findings that are applicable to them.
- Scholarship is a role that accredited CPD provider organizations can be expected to play – therefore they are part of an academy as learning organizations.

Determination of ‘preferable’ may require attention to the RELIABILITY of measurements in decision making.

Reliability promoted through efforts to reduce inexplicable variance so that variance in results is due to true differences between organizations.

Error variance reduced by the education and support of the people and organizations involved in the process.

Reliability usually requires repeated measures....but less important if not ‘high stakes’

Weaknesses

- Allows for activity accreditation only through ‘joint sponsorship’ or ‘co-providership’
- Extrapolates from past performance-in-practice vs. ‘what I plan to do’.
- Only accommodates those willing to do an organizational level self-assessment.
- Periodicity of review/input long time frame.
- Complicated
- More demanding
Summary
1. Economies of Scale and Scope
2. Business Efficiency and Effectiveness
3. Amplification Effect
4. Creating a Community of Practice
5. Communication Channels
6. Organizational Development
7. Reliability of Measurements
8. System as a Participant
9. Systems Evolve and Change
10. CME providers as an "Academy"

A Balance of Value vs Value
One must weigh the value of the benefits.

Attributes of Provider Accreditation need to be balanced with the number of activities an organization develops.

Maybe the benefits of provider accreditation always out weigh the costs.

Thank You
The future of learning in the professions: Outcomes-based continuing education and principles to help people learn and transfer their learning to practice

3rd National Optometric Continuing Education Conference
The Hilton Rosemont
April 27, 2013

Donald Moore, PhD

Financial Disclosure
- Speaker - Don Moore, PhD
- Professor of Medical Education and Administration
- Director, Division of CME
- Director of Evaluation, Undergraduate Medical Education
- I do not have any financial relationships with any commercial entity that makes or distributes products and/or services used by or on patients that are relevant to the content of my presentation.

Learning objectives
- After participating in this session, you will be able to describe and discuss:
  - An approach to outcomes-based continuing education for optometrists.
  - Principles that help people learn and use what they learn.
  - Why an outcomes-based approach to continuing education is important for regulating the practice of optometry.

The new conversations about learning (Marchese, 1997)
- In making choices about what to teach and how to assess it, we must communicate what we want students to learn.
- What we teach must be authentic; it cannot be abstracted from the venues where our students will want to use what they have learned.
- Deep learning is important for students to be able to transfer what they have learned to where they want to use what they have learned.
- Flow is a mental state in which a person performing an activity is fully immersed in a feeling of energized focus, full engagement, and enjoyment in the process of the activity.

Think, Pair, Share
- What was your most rewarding learning experience?
- Can you describe the experience in terms of:
  - Communication
  - Authenticity
  - Deep learning
  - Flow

Deep learning is important for students to be able to transfer what they have learned to where they want to use what they have learned.

Flow is a mental state in which a person performing an activity is fully immersed in a feeling of energized focus, full engagement, and enjoyment in the process of the activity.
Outcomes-based Continuing Education

- Start with the end in mind - outcomes framework
- Take into account stages of learning
- Focus on clinical problems and provide knowledge that can be used in practice
- Provide opportunities for practice and feedback in authentic settings

Professional practice gap

- Community Health
- Patient Health
- Performance
- Competence
- Learning
- Satisfaction
- Participation

What is wrong here?

- Traditional continuing education
- What should be annual dilated exams

Outcomes-based continuing education

- More explicit: to get closer to annual dilated exams for diabetics from 35-50% patients screened, use "outcomes-based continuing education."
Outcomes-based Continuing Education

- Start with the end in mind – outcomes framework
- Take into account stages of learning
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Outcomes-based Continuing Education

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Outcomes-based Continuing Education

- Start with the end in mind – outcomes framework
- Take into account stages of learning
- Focus on clinical problems and provide knowledge that can be used in practice.
- Provide opportunities for practice and feedback in authentic settings

Focus on clinical problems; provide knowledge that can be used in practice

Typical CE and transfer

Clinical Practice

Typical CE

Clinical Practice

ARBO 2013 NOCEC Report page 33
### Outcomes-based Continuing Education

**Opportunities for Practice and Feedback**

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  - Principles that help people learn and use what they learn.
  - Why an outcomes-based approach to continuing education is important for regulating the practice of optometry.

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**Transformation of Continuing Education**

Your plane will be flown by pilots who have been exposed to the principles of flight and the procedures used for successful take-offs and landings...

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**Thanks!**
APPENDIX C

PANEL DISCUSSIONS

Panel 1:
Continuing Education Accreditation .......................................................p. 36
Jill Martinson-Redekopp, OD, Moderator

- Kathy Chappell, MSN, RN
  Director, Accreditation Program, ANCC
- Dimitra Travlos, PharmD, BCPS
  Assistant Executive Director, and Director, CPE Provider Accreditation, ACPE
- Kate Regnier, MA, MBA
  Deputy Chief Executive and Chief Operating Officer, ACCME

Panel 2:
Industry Compliance .............................................................................p. 40
William Rafferty, OD, Moderator

- Dave Rybak
  Franchise Health Care Compliance Officer, Johnson & Johnson Vision Care
- Bhavana Desai
  Senior Director, Business Compliance Medical Affairs and R&D, Allergan, Inc.
- David Alexander
  Director Global Integrity and Compliance, Alcon

Panel 3:
Continuing Professional Development in the Era of Health Care Reform ........p. 42
Steven Eyler, OD, Moderator

- David Heath, OD, EdM
  President, SUNY College of Optometry
  Life-Long Learning in an Era of Accountability
- Linda Casser, OD
  Dean, Pennsylvania College of Optometry at Salus University
  Trends in CME - Identifying and Addressing Educational Gaps in Professional Practice
- Elizabeth Hoppe, OD, MPH, DrPH
  Founding Dean, Western University of Health Sciences College of Optometry
  Interprofessional Professional Competency and its impact on the future of Continuing Profession Development
An Overview of Three CE Accrediting Bodies
Accreditation Council for Continuing Medical Education
Accreditation Council for Pharmacy Education
American Nurses Credentialing Center

Kate Regnier, MA, MBA – ACCME
Dimitra Travlos, PharmD, BCPS - ACPE
Kathy Chappell, MSN, RN - ANCC

Purpose of Session –
• To describe a community of practice of other CE accreditors: size/scope, requirements, process, decision-making, and audit/reporting; and
• To provide an overview of the interprofessional collaborative program of Joint Accreditation – Accreditation of the Provider of CE by the Team for the Team

ACME’s Mission...
...the identification, development, and promotion of standards for quality continuing medical education (CME) utilized by physicians in their maintenance of competence and incorporation of new knowledge to improve quality medical care for patients and their communities.
...fulfills its mission through a voluntary self-regulated system for accrediting CME providers and a peer-review process responsive to changes in medical education and the healthcare delivery system.

Size/Scope of ACCME System

2011 Reporting Year

Accreditation Requirements

C1 Mission
C2-C6 Educational Planning to Close Gaps
C7-C10 Ensuring Independence
C11-C12 Organizational Self-Assessment
C13-C15 Improvement
C16-C22 Engagement
Policies that support the Criteria and/or responsibilities of Accreditation

Accreditation Process

Offers the provider opportunities to...
• Assess its commitment to and role in providing continuing medical education
• Determine its future direction
• Analyze its current practice

Three Sources of Data
• Self study report
• Review of performance in practice
• Accreditation interview
Decision Making

Accreditation Review Committee
- Integrates data into compliance findings
- Bases accreditation recommendations on findings

Decision Committee
- Reviews ARC recommendations
- Makes decisions & reports to Board

ACCME Board of Directors
- Ratifies actions of DC

Data Reporting and Audit

- Accreditation Process (every 4, 6 years)
- ACCME’s Program and Activity Reporting System (annually)
- Complaints/Inquiries

Mission and Purpose

The purpose of the Provider Accreditation Program is (i) to establish for state boards of pharmacy ... a mechanism for determining acceptable continuing educational credits required under law for the renewal of licensure and registration of pharmacists and pharmacy technicians, and, (ii) to assure and advance the quality of continuing pharmacy education thereby assisting in the advancement of the safe practice of pharmacy.

ACPE CPE Enterprise Data 2011

- Types of providers: Academia, Healthcare Networks, Educational Companies, National and State Associations, Publishers, Government Agencies, etc.
- 33,000 CPE Activities
  - 53% Live and 47% Home Study
  - 5 million statements of credit
  - 26% Live and 74% Home Study

Continuing Pharmacy Education

Current Evaluation Process

ACPE Board of Directors
Approve Action & Recommendations Report

CPE Commission
Draft Action & Recommendations Report

Comprehensive Review Rubric Evaluation Form
Conference Call

Commissioner Field Reviewer ACPE Staff

Standards for Continuing Pharmacy Education: CPE Activities

<table>
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<tr>
<th>Activity (Knowledge, Application, Practice)</th>
<th>Activity Purpose</th>
<th>Minimum Credit</th>
<th>Learning Assessment</th>
<th>Assessment Feedback</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge (Questions/review of facts)</td>
<td>Transmit knowledge</td>
<td>15 minutes</td>
<td>Questions/review of facts</td>
<td>Must be provided to all learners</td>
</tr>
<tr>
<td>Application (Case studies/application of principles)</td>
<td>Apply information</td>
<td>1 hour</td>
<td>Case studies/application of principles</td>
<td></td>
</tr>
<tr>
<td>Practice (Insist on knowledge, skills, attitudes) (Programs)</td>
<td>15 hours</td>
<td>Demonstration workplace, simulation</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Standards for Continuing Pharmacy Education

Evaluation of Achievement and Impact of CPE Mission and Goals

- Knowledge-based CPE activity
  - Participation
  - Satisfaction
  - Learning
  - Performance
  - Patient Health
  - Population Health

- Application-based CPE activity
- Practice-based CPE activity

ANCC Mission

The mission of ANCC is to promote excellence in nursing and health care globally through credentialing programs and related services.

Through credentialing, ANCC improves the professional practice of nurses, the environment where nurses practice, and care to the clients/patients they serve.

- Accreditation
- Certification
- Magnet & Pathway to Excellence

Size and Scope

- Accredited Providers and Approvers (~400)
- Approved Providers (~1,200 – 1,500)
- International Providers: Lebanon (1), Jordan (2), Turkey (1), Singapore (3), Australia (1), Scotland (1), Egypt (1)
- Accredited Providers: >28,000 activities / >8,000,000 participants
- Approved Providers: >68,000 activities / >2,000,000 participants
- Individual Activities: >4,000 approved / >200,000 participants

Educational Design Process

Miller’s Model of Clinical Competence

Knows: learner has knowledge about the topic/subject.

Knows how: learner is capable of applying the knowledge.

Knows how/does: learner is able to apply knowledge and skills in a simulated setting (Knows how) or the practice environment (Does).
Data Collection

- Activity volume
- Target audience
- Format of activities
- Evaluation/impact level of activity
- Financial support for activity
- Target audience

Auditing/Evaluation

- Random compliance audits
- Monitoring reports post-accreditation decision (progress reports)
- Complaints

Joint Accreditation (n=9 orgs; 7 in process)

- Provider Accreditation with a focus on interprofessional education (IPE)
- Criteria developed to support IPE and practice-based learning and improvement
- Process: Three data sources (self study report, activity files, interview); shared decision-making
- ACCME, ACPA and ANCC collaborative administration of program
- Working to streamline the “back end” – fees and reporting

Questions?
ARBO Industry Compliance Panel

D. Rybak
April 27, 2013

Disclosure

- The opinions and views contained in the following presentation represent my personal views and are not necessarily those of Johnson & Johnson or affiliates.

Historical Perspective
OIG Compliance Program Guidance for Pharmaceutical Manufacturers – May 5, 2003

- Elements for an effective compliance program
  - 7 Elements introduced
  - Highlighted specific risk areas
    - Government Reimbursement
    - Kickbacks and other illegal remuneration
    - False Claims
  - Key Areas of Potential Risk
    - Discounts
    - Product Support Services
    - Educational Grants
    - Other remuneration to purchasers

Historical Perspective
OIG Compliance Program Guidance for Pharmaceutical Manufacturers – May 5, 2003

To reduce the risks that a grant program is used improperly to induce or reward product purchases or to market product inappropriately, manufacturers should:
- Separate their grant making functions from their sales and marketing functions.
- Establish objective criteria for making grants and to ensure that the funded activities are bona fide.
- Ensure that the manufacturer should have no control over the speaker or content of the educational presentation.
- Compliance with such procedures should be documented and regularly monitored.
ARBO 2013 NOCEC Report page 41

Historical Perspective

Transparency: Grassley to Medical Groups: Reveal Financial Payments from Device Firms – December 2009

- Sen. Chuck Grassley (R-Iowa) asked medical organizations for information about payments received from medical device companies.
- Sent to 33 medical groups
- One of multiple communications to institutions, groups, and manufacturers from Sen. Grassley and Sen. Kohl

Historical Perspective

Why Rules Continue to Appear to be Tightening

- Variation of interpretation of Anti Bribery Laws
- Whistle blower incentives
- Settlement Financial Returns
  - 2012 Settlements: $6.4 Billion
    - GSK $3.0 Billion
    - Abbott $1.5 Billion
- Affordable Care Act including Sunshine
- State Laws
- Revisions of Voluntary Codes
  - PhRMA
  - AdvaMed
Factors impacting the development of Practice “Gaps”

- The Population Served
- Expansion of Knowledge/Discovery
- Revision of Knowledge
- Clinical Care Guidelines as a reflection of knowledge and standard of practice (Evidence-based)
- Scope of Practice
- Time

Theoretical Characteristics of the Life-Long Learner

- Curious
- Motivated
- Reflective (self aware)
- Confident
- Persistent
- Disciplined
- Methodical
- Analytical
- Flexible

Institute of Medicine (2009): Redesigning Continuing Education in the Health Professions

“In its current form, continuing education often is associated with didactic, teacher-driven learning method, such as lectures, conducted in traditional settings, such as auditoriums.”

- Major flaws (designed, financed, evaluated)
- Science of CPD underdeveloped
- Interdisciplinary
- A comprehensive vision to replace the current culture
- Establishing a national interprofessional CE institute

Source: Institute of Medicine, Redesigning Continuing Education in the Health Professions, Report Brief, Dec 2009
Moore’s CME Outcomes Measurement

- Level 1 – Attendance
- Level 2 – Satisfaction
- Level 3 – Learning
- Level 4 – Competence
- Level 5 – Performance
- Level 6 – Patient Health
- Level 7 – Community Health

Self Assessment Modules (SAMs): Defining the Gap, Establishing the Goal

Enhancing competencies in those areas most critical to practice
- Knowledge Assessment
  - Assessing knowledge in a particular domain
  - Domains are defined by core competencies
  - If unsuccessful – shifted into review mode which offers critique and
    references
  - Once successful, move into ->
- Clinical Simulation
  - Case Scenarios reflecting the domain
  - Dynamic case which evolves based on treatment, intervention, time, etc.
  - Demonstrates proficiency in patient management
- Receive CPD/CME/CE credits

Performance in Practice Modules (PPMs): Defining the Gap, Establishing the Goal

Assessing improvement in patient care using established quality indicators
- Generally correspond to SAMs
- Enter data for set of patients > feedback provided on those
  patients against a set of indicators
- Selection of indicator for intervention/improvement
- Design, submit and implement plan in practice for improvement
- Reassess using patient data to compare pre- and post-
  intervention performance.
- Receive CPD/CME/CE credits

Education & Assessment in Post-Graduate Competency

- Data Board
  - Residency Expectations
  - Positional
  - Complementary degrees & certificates
- Maintenance of licences (MOL)
- Board Certification (e.g., Family Practice)

Health Care Delivery System
- Appointment/Credentials/Privileging
Regulatory Influences in Optometry

Transitioning from an internal (professionalism) to external (the system) accountability model.

When “trust me” is no longer enough.

Thank you
Interprofessional Competency and its Impact on Continuing Education

Elizabeth Hoppe, OD, MPH, DrPH
Founding Dean, College of Optometry

What is Interprofessional Care?
Team-based health care is the provision of health services to individuals, families, and/or their communities by at least two health providers who work collaboratively with patients and their caregivers—to the extent preferred by each patient—to accomplish shared goals within and across settings to achieve coordinated, high-quality care.


What is Interprofessional Care?

Interprofessional team-based care: Care delivered by intentionally created, usually relatively small work groups in health care, who are recognized by others as well as by themselves as having a collective identity and shared responsibility for a patient or group of patients, e.g., rapid response team, palliative care team, primary care team, operating room team

http://www.aacvs.org/education-resources/teamreport.pdf

What is Interprofessional Care?
The provision of comprehensive health services to patients by multiple health caregivers who work collaboratively to deliver quality of care within and across settings.

Ministry of Health & Long-term Care, Province of Ontario, 2007

Why is Interprofessional Care Important?


Why is Interprofessional Care Important?

Why is Interprofessional Care Important?

- Affordable Care Act

"By this act, the Patient-Centered Medical Home Act of 2013 (the "Act") amends the Patient-Centered Medical Home Act (the "Medical Home Act") in order to implement the Act, beginning January 1, 2013, in the provision of a patient-centered medical home for every Medicare beneficiary, including enrollees in Medicare Advantage plans.

"(3) HEALTH HOME. — The term "patient-center medical home" means a patient-centered medical home as described under subsection (h), a team of health care professionals as described under subsection (j), operated by a provider as described under subsection (b), or a health team as described under subsection (k) that is recognized as a patient-centered medical home for the purpose of providing the individual with health care services..."
Why is Interprofessional Care Important?

2011 conference convened by the Health Resources and Services Administration, the Josiah Macy Jr. Foundation, the Robert Wood Johnson Foundation, and the ABIM Foundation, in collaboration with IPEC. The publication of the proceedings, Team-Based Competencies: Building a Shared Foundation for Education and Clinical Practice.

Why is Interprofessional Care Important?

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What is the Bottom Line?

- Patient Safety
- Health Outcomes
- Cost Savings

FIGURE 4: Barr’s (1998) three types of professional competencies

“Collaborative” competencies are those that each profession needs to work together with others, such as other specialties within a profession, between professions, with patients and families, with non-professionals and volunteers, within and between organizations, within communities, and at a broader policy level.

http://www.aacn.nche.edu/education-resources/ipereport.pdf

ARBO 2013 NOCEC Report page 47
What Skills are Required?

Interprofessional Collaborative Practice Competency Domains

1. Values/Ethics for interprofessional practice
   - 10 specific competencies
2. Roles/Responsibilities
   - 9 specific competencies
3. Interprofessional communication
   - 8 specific competencies
4. Teams and teamwork
   - 11 specific competencies

Why is Interprofessional Continuing Education Important?

- Institute of Medicine

http://www.iom.edu/ObjectHandler/ObjectHandler.aspx?PageID=53178 & Title=Redesigning%20Continuing%20Education%20for%20the%20Health%20Professions

INSTITUTE OF MEDICINE
OF THE NATIONAL ACADEMIES
Ten Recommendations
1. Commission a planning committee to develop a public-private institute for continuing health professional development.
2. The planning committee should design an institute.
3. Improve quality and safety.
4. Improve scientific foundation for OPD.
5. Enhance data collection.
6. Develop national regulatory standards.
7. Strengthen financial support.
8. Foster development of interprofessional models.
9. Support research.
10. Evaluate progress.

Observations: Barriers and Challenges
- Integrating asynchronously in different locations
- Perceived competition
- Process for approval of CE/CME credit
- “Approval” of speakers/content experts

III. Instructor(s):
A. Instructor(s) must have the necessary qualifications, training and/or experience to present the course. With the exception of courses categorized as Practice Management, Principal Instructor(s) must hold a minimum of a doctorate-level degree (O.D., M.D., Ph.D., D.O., J.D., D.D.S., D.C., Pharm.D., L.L.D., D.Ed., D.Sc., etc.)
<table>
<thead>
<tr>
<th>Observations: Barriers and Challenges</th>
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<tbody>
<tr>
<td>• Integrating asynchronously in different locations</td>
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<td>• Perceived competition</td>
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<td>• Process for approval of CE / CME credit</td>
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<tr>
<td>• “Approval” of speakers / content experts</td>
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<td>• Topics of interest</td>
<td>• Topics of interest</td>
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<tr>
<td>• Perceived value for this type of education</td>
<td>• Perceived value for this type of education</td>
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<table>
<thead>
<tr>
<th>Observations: Barriers and Challenges</th>
<th>Opportunities</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Integrating asynchronously in different locations</td>
<td>• Topics of common interest</td>
</tr>
<tr>
<td>• Perceived competition</td>
<td>– Chronic and common</td>
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<tr>
<td>• Process for approval of CE / CME credit</td>
<td>– Complex</td>
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<tr>
<td>• “Approval” of speakers / content experts</td>
<td>– “Orphans”</td>
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<tr>
<td>• Topics of interest</td>
<td>• Technology Solutions</td>
</tr>
<tr>
<td>• Perceived value for this type of education</td>
<td>• What are the rewards?</td>
</tr>
<tr>
<td>• Common language / terminology</td>
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## APPENDIX D

### BREAKOUT GROUPS

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<tr>
<th></th>
<th>Group A</th>
<th>Group B</th>
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<td><strong>CE Planning and Outcomes</strong></td>
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<tr>
<td><strong>Facilitator</strong></td>
<td>Christina Sorenson</td>
<td>Jill Martinson-Redekopp</td>
<td>Susy Yu</td>
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<tr>
<td><strong>Assistant Facilitator</strong></td>
<td>Roger Pabst</td>
<td>Bill Rafferty</td>
<td>Michael Ohlson</td>
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<td><strong>Recorder</strong></td>
<td>Janet Carter</td>
<td>Bruce Rakusin</td>
<td>Dale Dergousoff</td>
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<tr>
<td><strong>Participants</strong></td>
<td>Christine Allison</td>
<td>Dale Atkinson</td>
<td>Larry Alexander</td>
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<td>Joe Barr</td>
<td>Susan Atkinson</td>
<td>Anthony Borgognoni</td>
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<td>Bart Campbell</td>
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<td>Regina Combs</td>
<td>David Heath</td>
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<td>Steve Eyler</td>
<td>Theresa Jowell</td>
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<td>Elizabeth Hoppe</td>
<td>Melissa Padilla</td>
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<td>Barb Horn</td>
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<td>Jim Hunter</td>
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<td>Jeanne Oliver</td>
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<td>Nick Opitz</td>
<td>Elizabeth Taylor</td>
<td>Mary Lou French</td>
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<td></td>
<td>Nancy Peterson-Klein</td>
<td>Jack Terry</td>
<td>Greg Moore</td>
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<td></td>
<td>Dave Rybak</td>
<td>Holli Tirabasso</td>
<td>Ken Myers</td>
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<tr>
<td></td>
<td>Robin Simpson</td>
<td>Murray Turnour</td>
<td>Michael O’Hara</td>
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<td></td>
<td>Helen Viksnins</td>
<td>Karla Zadnik</td>
<td>Ernie Schlabach</td>
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<td></td>
<td>Rick Weisbarth</td>
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<td>Dick Wallingford</td>
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Appendix F

Notes from Discussion Groups

Discussion on the Topic of CE Planning and Outcomes
(Breakout Group A)

Participants were asked to define what Optometry needs education for, and what optometric Continuing Education (CE) means to us as providers and consumers. The following list came from the participants:

1. CE fulfills the needs of the practitioner to meet their state laws.
2. CE is a business.
3. Ideally optometrists take CE for the purposes of professional development and not just to comply with state law.
4. We need to maintain the public trust.
5. CE allows our colleagues to keep in touch with changes in technology and scientific knowledge, especially in light of the restrictions on industry in terms of what they can discuss (in terms of products and techniques).
6. CE provides an opportunity for practitioners to connect with each other.
7. CE gives providers an opportunity to learn procedures and techniques that come about as a result of new technology and equipment.

The following questions were asked of the participants by the moderators and discussed:

Why do people become providers of CE?

1. It can be a good income stream.
2. They enjoy sharing their knowledge with others.
3. for networking purposes….. (Do we lose something in an online environment when we can’t share and “bounce information” off of each other?)
4. Topic-based needs….sometimes it’s a challenge to find a speaker who is knowledgeable on a specific topic or can give a unique perspective, so those who can do so will be asked to contribute.
5. Speakers need to present for professional development, and to perfect their presentation style.

What are the motivations of organizations that sponsor CE?

1. Service to membership; to bring membership together; to attract membership
2. Profit
3. “Promote the science and research in vision care”
4. Meet the needs of association members as laws and technology change
5. Bring the membership together to network with each other and industry.
6. To meet changing needs as legal requirements and scope of practice increase. Gaps have been identified in membership needs and/or knowledge.

: Have we spoiled the concept of CE by having too many stakeholders (i.e. by making it too profitable)?
Are there different tiers of CE level being provided based on providers (i.e. do smaller providers give a different level of CE than that given by a national provider/organization? Is all CE the same, or does quality vary greatly? How are subject matters chosen? Are the subjects covered at meetings based on need, or just what draws?

Examples were discussed of differences between local meetings and national meetings. One provider commented that her organization will organize meetings around subject matter that draws the most attendees (i.e. glaucoma meetings are always well-attended, possibly due to requirements brought about by scope expansion under state law. However, other subjects – pediatric optometry is one she mentioned specifically – often result in poor attendance and therefore aren’t covered nearly as often, especially in the larger meetings where good attendance is required to cover costs).

Robin Simpson (British Columbia, Canada) reported on peer groups that discuss cases (usually manufactured cases) in a small group setting….the Provincial College (equiv. to US state regulatory board) gives CE credit to ODs that participate in small group sessions (six to eight docs) discussing these cases. They will pick a subject matter based on need (i.e. glaucoma because they just got glaucoma certification in BC), or based on the ongoing assessment via chart review that occurs in BC). The College prepares mock cases for discussion, and will purposely have treatment errors in the manufactured records (without revealing the nature or number of errors in the case). The small group can discuss proper treatment and management. Furthermore, none of the participants are singled out to answer specific questions, and therefore it has proven to be a non-threatening and non-punitive environment that is very conducive to learning. There was general discussion on how this could be utilized by other regulatory bodies, and how to add these “teaching moments” to our CE options.

One participant pointed out that they have a CE committee in their state association that is a one-person show, and seems more motivated by getting sponsorship than in finding interesting speakers. Workshops seem to be especially of interest to younger practitioners, who are more used to “hands on” education.

“Millennials” seem to have different tolerance for “sitting still” (different learning styles). They need to see a value in class, and react well to workshops (like the interaction). So you must plan for this as these folks are increasingly your consumers. Different groups and individuals process information differently, and these differences are amplified by the so-called digital divide. The challenge that many educators face is that they teach based on their generational/learning experience, but their students may have a totally different outlook and learning style (and may use very different technology). We need to adapt to how they learn….we can’t force them to learn the way we want to…

There was general discussion about online learning opportunities and their availability and effectiveness. These can be useful for pre- and post-activity assessment and outcomes assessment. The challenge is figuring out how to deal with the gap that exists between the technology-savvy and those who simply haven’t been exposed to it. Online learning also is challenging to document in terms of participation, and often may be in formats that aren’t totally conducive to the granting of traditional “credit hours”

“Seeing is Believing” is an example of a new virtual CE conference that has proven to be very popular. Other examples of online CE were discussed.

ARBO 2013 NOCEC Report page 54
But with virtual learning opportunities there must be some type of assessment (either mandated or self-selected) so that outcomes can be determined (and attendance verified).

To sum up the first half of the discussion: …We want to get beyond just a lecture situation to include more comprehensive educational tools, including the hands-, workshops, Board Certification models, reviewing records, online assessments, etc. These are all key points: to move beyond learning to competencies.

So how do we define CE opportunities and outcomes in the future?

Opportunities for CE:
1. Online CE and assessment
2. Workshops
4. Asynchronous learning – with opportunities for interaction after the webinars
5. Hands-on learning (Grand Rounds; standardized patients; practitioner assessment via records review).
6. Different forms of live CE: (lectures, symposia, panels, etc.).
7. Papers/posters
8. Roundtable/small group discussions
9. Mentor/Mentee CE.
10. “Up to Date” an online service that references evidence-based medicine.

But we need to know our outcome goal to know which of these will work and how. What do we mean by core competencies? We need some type of feedback loop or activity-related means of assessment.

We also need to understand what our objectives are in providing CE. Regulators may have a different objective (i.e. do no harm) than educators (who are trying to expand overall knowledge base). CE must do both; it must go beyond minimal standards. Licensing sets the goal posts, but the goal posts keep moving….so how do we keep the practitioner informed of where those goals are? The purpose of CE is to keep the practitioner informed of those changes. You need to expand the practitioner’s knowledge base and also keep him current (especially as scope of practice and/or technology changes).

Maybe you need two different streams of CE: one for insured competency, and one for “best practices” (i.e. to be the best possible practitioner).

What ARE our options? How do we judge outcomes? How do we use evidence-based practice vs. personalized care (especially if we are dealing with a patient outside the norm)? We need to better identify our knowledge and performance gaps. To some extent we need the hammer…i.e. the assessment at the end to insure people get to the necessary level for safe and effective practice. Scope of practice expansion has helped, but it has drawbacks….as you concentrate on scope of practice expansion you need to make sure you don’t forget the areas that aren’t involved. (I.e. lack of concentration on binocular vision as you become certified in glaucoma).

So we need evidence-based CE, and we need to expand the width of CE as well as the breadth…..Developing a culture of life-long learning with excellent outcomes.

Optometry has to be paid to do CE (to lecture) whereas in other professions it is considered an honor to be asked to give lectures, and no payment is expected. So we need to look at the culture of the provider, and how they are compensated. Also there is a difference in how physicians practice in that they are regulated by hospitals as well as regulatory boards. There was
discussion on how appropriate self-assessment is. And if we DO identify weaknesses, do we take the necessary courses to remediate? CE should be an attempt to build on your knowledge base.

We are looking at two types of assessment (both self- and practice) with two levels. One is formative (take the test and give feedback to yourself) and another that is summative / assessed by someone else. The latter could be a significant hurdle. We need to try and think of assessment as validation or practice development (Assessment is scary….). We need to change the culture on SAM/PMs gradually…and ease into changes. (Start out being voluntary).

What might work is a situation where we do a self-assessment that can help us identify our deficiencies, and then points us back to research information/ available COPE courses, etc. to help learn more…followed by a second assessment (perhaps with additional CE) to see how we might have improved.

Barriers: Change in culture on SAM/PM formative/summative
Jurisdictional (i.e. “hours” needed)
Participant: one event for all CE courses; repeated courses

Discussion on the Topic of Provider vs. Activity Accreditation
(Breakout Group B)

Facilitator: Jill Martinson-Redekopp
Asst. Facilitor: Bill Rafferty
Recorder: Bruce Rakusin
Presenter: Melissa Padilla

Bullets from 2006:
Looking at Uniformity of states for CE Approval
Matching ACCME standards in CE
Moving towards Provider Model of Accreditation
As COPE uses activity accreditation Model

Change of terminology from:
Administrator to Provider
Event to Activity
COPE has some ACCME standards integrated within its standards. They are not broken out separately. COPE is missing 2 elements: accountability to meet learning outcomes…Did provider present material pertinent to learning objectives. How are learning outcomes measured to address the practice gaps?
Resolution at the 2012 Annual ARBO meeting was made to move forward with the process of Provider Model of accreditation similar to that used by ACCME

Activity level:
Less expensive for individual group
Consistency
Easier for smaller provider
Oversight process easier
Content review at a more granular level
**Provider model advantages:**

(Would need track record that you could do it consistently over time to become Provider)  
Better for groups putting on >14 activities if ACCME estimates are applicable to optometry  
Better for outcome assessment  
Good for large established groups with resources  
May allow standards to be raised  
May be easier to fill out grant processes  
Freedom to groups without as much direct oversight but more accountability  
Assessing needs and defining a program for educational planning.  
Tract education may be considered  
Easier to focus program on outcomes  
Greater creativity would be possible

Need to aspire to highest educational goals  
Find the educational gaps and design courses to address this  
This will produce better outcome for patients in the long run  
Consistency may be better with Provider model and used to grant writing

**Current status of Provider Model Accreditation:**  
May be able to use resources better with this model  
Some Providers have asked if COPE could be consistently listed in the drop down menus of accreditation choices for the industry grant applications.

**Could 2 systems exist…Activity and Provider**

Local societies could be accredited via larger group  
Terminology is an issue  
States could continue to approve courses if they chose to do  
Must keep the same set of standards whether Activity or Provider. Some feel this would be difficult to accomplish.  
Expectations of the quality of the activity should be parallel  
Needs/Design course/assess QI in their organization

Should we use ACCME as a template for further study or are there other systems we could adopt?  
Evidence-based decision about credit equivalency. (Salus University has established an institutional credit equivalency process. Perhaps something similar could be developed for COPE?)

**Consider replacing CE with CME**  
Address this with state laws so maybe not a necessity

**Wrap up comments**
DAY 2

Equivalency is an issue to be discussed by COPE
It would be nice to move toward a more standardized way of providing CE at a higher level.

Independence for Commercial support in CE:

ID by reviewing outline and discussing with speaker
By following COPE requirements they address this issue
Examples of COI and CE monitoring:

1. ID Financial relationship with a company by the speaker
2. Systems to avoid comingling the educational and marketing pool of funds.
3. Screen for branding….then told to use general brands if conflicts are found
4. Reviewing speakers slides and ID anything that is not appropriate
5. Use CE monitors at the course
6. Getting actual slides prior to presentation to compare to original
COI in the planning? Is this a step that is being missed?
7. Committee might need to complete form showing ties to companies. Grant process has changed this approach as everything has gone to unrestricted grants.
8. Marketing talks can still be presented, but not for CE.
9. Promote uniformity by stressing to state boards to follow these SCS rules at the state board level.

Other things to consider at CE planning:

1. Monitoring for off color jokes
2. Look at disclosure and make sure they are verbally announced
3. Can’t give same lecture within 30 days before and after

Discussion on the Topic of Future Deliveries of CE
(Breakout Group C)

1. Current status of the Future Deliveries of CE

Live vs. Online
Times are changing - different formats available
What format is more valuable now.
What does the term CE now mean - structure, standardization?
What is the answer - how do we create meaning to CE?
Does CE format matter - Are state boards willing to change their mindset – as well as change statutes and regulations?
There can be a financial benefit to state and provincial associations in providing live CE. In order for alternative delivery modes to be effective these organizations must have a means to participate as well.
Learner focused vs. instructor focused - There is an opportunity for both to exist to meet the needs
Will change in format cause a change in corporate financial support - drive CE prices up? 
CME (Continuing Medical Education) faces some of the same struggles we are discussing - best 
practices are still yet to be defined 
Lot to still be learned about intraprofessional world 
Need a national consensus to make it work properly? 
CE hours has been driven by scope of practice in each state - need for evidence based data? 
We have limited portability of licensing - creates a challenge 
Could ABO program be helpful going forward by creating the national standard? 
ABO MOC requires testing to substantiate CE 
Tough to outline individual state statutes/regs 
States require hours in certain topics - another challenge 
WE need to know what we need to know in order to design the educational experience? 
State boards will limit changes in the next 10 years, but can we create other formats/vehicles in 
the meantime. Create a parallel pathway for now. 
Misunderstanding of COPE with state boards? 
What motivates people to take CE - they need it for their license 
Equivalency documentation 
ARBO’s relationship with states using COPE - could COPE create higher standards than all the 
states which would allow states to defer to that? (a National Clearing house)?

2. Advantages/Disadvantages of the Future Deliveries of CE


CE format should matter to the learners needs and wants - know your audience, learning style 
preferences, online behavior - 13 minutes is the average time will focus 
How can optometry learn from mistakes that Medicine experienced 
Medicine now gives credits, no longer credit hours – 
CE matters to state boards move to performance based 
Some presenters are far better on-line (e.g., pulling technologies together) than in person. 
Students today do not learn using the same technologies (e.g., book versus computer screen).

Criteria for learning
Current methods are antiquated, dependent on presenters 
Didactic - creates limitations 
Online - allows for more creativity and more complete CE 
Do we wait and see or do we learn from others and move forward? 
Know your audience - communicate with them find out from the audience what works better, 
generation differences for learning - have to create different learning pathways 
Intraprofessional challenges - engaging the different audiences’ differences in learning

Andragogy - adult learning 
We want to choose what interest us 
Experience add to the conversation 
Pedagogy = child learning  
* Instructor center: small bites; external carrot / stick; 
Needs to relevant and meaningful, convenient 
Intrinsic motivation to learn
Self-directed
Real time learning

4. What are the barriers to implementation of these delivery systems?

Learner focused vs. instructor focused
50 State boards with 50 different requirements: lack national consensus; thus diverse standards
Will change in format cause a change in corporate financial support - drive CE prices up?
We have limited portability of licensure - creates a challenge
WE need to know what we need to know in order to design the educational experience?
State boards will limit changes in the next 10 years, but can we create other formats/vehicles in the meantime. Create a parallel pathway for now.
Equivalency documentation

5. What is the recommended action plan?

Educational formats
Interactivity to CE - how critical is it
Peer Circle review in BC

Online Learning - accessible, inexpensive
Werkz Publishing - digital learning
Millenial Generation - sheltered, confident, team orientated achieving, pressured, ---- info on demand, they pick and choose, they know what’s best, collaborate, sharing of opinions, read reviews ratings

Demy - democratic education can teach anyone anywhere in the world, course reading and reviews, instructors is the best in the world

Courser - modular units from best universities in the world, students practice with the material to really understand, use technology to grade homework, able to interact with anyone in the world at their convenience

Studio Schools - work and learning are integrated, non-cognitive skills are as important as cognitive, 80% is project based

How should we defining equivalency/how should CE unit be defined

Is time still the right measurement?
Outcome based, what is the level of outcome - should be flexible
People process things very differently
Self-assessment models? Give them private information of what they don’t know and direction as to help them gain the knowledge,
If we put in x number of hours would we get the information we need to change performance...input=output
CE hours went up arbitrarily with changes in scope - there was no evidence based information stating what is required to maintain competency
System based on hours

ARBO 2013 NOCEC Report page 60
Antiquated lecture system?
Other formats - but how do we incorporate them into traditional time based increments, may be impossible to create - start with 50 min is equal to 1 unit
Do we use CE unit? Use of COPE will allow standardization - can develop an equivalency options to 1 CE hour
Do we change our terminology to be similar to ACCME, develop equivalency in some type of format - can we develop outcome based on a sliding scale

Outcome measurement?
Could it be done on sliding scale?
Based on format

Intra-professional accreditation - tremendous value but need to get our own house in order Similar standards and similar terminology will allow for more access, open more access to knowledge, what is the value in pursuing this; change is up to us to meet their standards.

WHAT IS THE CONSENSUS ON THE SOLUTION SET?
Summation from whole discussion
A. Terminology of equivalence 1 "hour" = 1 CEUnit
B. Develop equivalency option to 1 CEU (e.g., fraction of questions answered correctly after receipt of CE)
C. outcome measurements on a sliding scale
D. future must welcome CE in formats in addition to lectures

Do traditional methods have future?

DAY 2
FUTURE DELIVERIES OF CE
CURRENT STATUS
Wide variation in state board requirements of CE. CE hours requirement is state legislates. Change in requirements often due to change in scope.
MOC requirements include CE hours
Payers Requirements
Discussion:
Do we want National Clearinghouse?
Some states have no specific requirements for CE required for Medicine Education needs to more effective and require positive patient outcome

ADVANTAGES/DISADVANTAGES
Live vs. Online - Live lecture is not always most effective method of influencing outcome/learning. Alternative learning formats could be as or more effective. State associations both adv. and disadv.
Disadv - constraints
Can’t be nimble under the current system - would be beneficial to have quarter hour increments
Nimble in the approval process would help
Academy does hands on workshop
Alternatives - more flexible options online, workshops,
Alternative methods are also a disadv. Because they may result in lower attendance
Corporate Money is in live CE
Millennials how do we handle them

Impact on knowledge performance patient outcomes

CE should be planned delivered and measured to improve patient outcome

CE should incorporate theories of adult learning: what the learner wants to know, when he/she wants to learn it in a manner that is relevant

Need a starting point with state boards, equivalency does help with this
Nimbleness - requires coordination with state associations, boards - ARBO could develop this and take it to the state boards with as system the avoids changes in state regs

Barriers to implementation

State regs and statutes define CE requirements. Difficult or politically not advantageous to change

Consider financial impacts for learners and CE providers - State associations (could be a barrier but also a potential partner) Responsibility needs to come from the profession as a whole

Operational barrier: Data collection
APPENDIX F

POSITION PAPERS

American Academy of Optometry.................................................................p. 64
American Optometric Association...............................................................p. 68
Association of Schools and Colleges of Optometry.....................................p. 69
National Board of Examiners in Optometry.................................................p. 73
Association of Regulatory Boards of Optometry........................................p. 76
Today's Research, Tomorrow's Practice®:
The Academy's Perspective on Improving Knowledge, Performance and Patient Outcomes in Optometric Continuing Education

The mission of the American Academy of Optometry is to promote the art and science of vision care through lifelong learning. Fundamentally, the Academy's very existence demonstrates the intention to improve knowledge, performance and patient outcomes. The Academy's vision is to provide a forum for today's research that can most effectively guide tomorrow's practice.

The Academy was founded in 1922 by insightful leaders who recognized that there was a need for a learned body to develop the science of optometry and to disseminate that knowledge to optometrists. It was the extraordinary vision of the Academy forefathers who wanted to provide the profession with a scientific base. From those very beginnings, the Academy has been fortunate to be filled with talented individuals who are committed to the betterment of the profession and whose efforts have resulted in preservation of sight and protection of the visual welfare of the public.

The Academy is truly the only organization in optometry that has the unique ability to bring together the scientists, clinicians and educators to present their outstanding discoveries, so that those discoveries can be blended into the clinical
care optometrists provide their patients. The Academy also provides recognition and highest honors in the profession for world-renowned scientists, humanitarians, distinguished educators, and other professional service leaders through its awards program.

The Academy Improves Knowledge through its annual meeting, chapter gatherings, journal and foundation.

During the Academy’s annual meeting there are many opportunities to achieve the goal of improving knowledge through evidence-based clinical continuing education. There are over 200 hours of lectures and workshops in diverse areas across the spectrum of optometric knowledge. At Academy 2012 Phoenix, over 5,000 individuals attended more than 30,000 hours of continuing education. This education program is crafted through the diligence of the Lectures & Workshops and Scientific Program committees who spend countless hours as volunteers selecting courses and abstracts from an ever increasing pool of submissions.

The Academy provides a unique milieu for the sharing of the research discoveries with clinicians. In the Section and Special Interest Group symposia and special events, such as the Plenary Session in 2012 on autism spectrum disorders and the Hirsch Research Symposium on macular degeneration, attendees learn from top researchers in the field about their noteworthy discoveries. The Scientific Program Committee invites senior vision scientists to give keynote presentations on selected
topics. These spotlighted events provide attendees with an overview on the field of research and some insight into unanswered questions. This year’s keynote presentations were delivered by Dr. Eli Peli of Schepens Eye Research Institute: *Eye Movements and Impaired Vision – A New-Old Frontier* and Dr. Ronald Harwerth of the University of Houston College of Optometry: *Improving Structure Function Relationships for Clinical Use*. There are plans afoot to not only continue these keynotes at Academy 2013 Seattle, October 23-26, but to expand scientific sessions into hybrids where scientific discovery is linked to practice guidelines for improved patient care.

The Academy’s journal, *Optometry and Vision Science*, continues to be one of the top-ranked vision science journals with a 29% increase in citations last year alone which improved its impact factor. It receives record numbers of manuscript submissions and features issues with themes of interest to practitioners, like last year’s *Imaging Advances in the Eye* (May) and *Low Vision* (September).

A final aspect through which the Academy improves knowledge in the vision science community is through its foundation, the American Optometric Foundation (AOF). The AOF is the Academy’s philanthropic arm. While the annual meeting provides a forum for presentation of research and *Optometry and Vision Science* promotes the publication of new research, it is the AOF that directly supports research. By funding the future of optometry through its scholarship and awards programs, the AOF gives exceptional students and future academic leaders the opportunity to continue their
education and propel the field of optometry and vision science forward. With an endowment of over $4 million, the AOF is on target to award $500,000 in Fellowships, Scholarships and Grants in 2013.

In terms of **Enhancing Performance**, the Academy's workshops have historically provided attendees with hands-on experience using new or intricate techniques and new technology, guided by skillful presenters with significant experience. These sessions have limited attendance and ample supervision to ensure that doctors are able to understand and integrate into better patient care. At last year's meeting, a new question was added to evaluation forms for all education: Will this learning change your practice? Ninety-two percent of the workshop attendees answered: "Yes." A direct link between gaining knowledge and enhancing performance!

With respect to **Patient Outcomes**, contrary to popular belief that most Academy members are academicians or scientists, 88% of our members see patients. A significant reason for optometrists and vision scientists to join the Academy and achieve Fellowship is they value attaining the highest standards of competency in their areas of practice. Fellows and Diplomates in the American Academy of Optometry foster professional growth and advocate excellence in patient care through leadership in education and research. Their most significant goal is to ensure that their patients are provided the most up-to-date diagnoses and treatment options for the best quality of life.
NATIONAL OPTOMETRIC CONTINUING EDUCATION CONFERENCE

Promoting improvement in knowledge, performance and patient outcomes for the public welfare.

The American Optometric Association (AOA) has long been an advocate of policy that promotes the best possible care for the public and is pleased to participate in this profession wide effort to meet a number of important objectives pertaining to Continuing Education for Optometrists.

The AOA recognizes the significance of the need of our members for the translation of new developments in research and understanding of the diagnosis and management of eye and vision disorders into usable practical information that can be put into practice to benefit our patients. Consistent opportunities to attain such practical Continuing Education will require a fresh look at the methods and formats used to develop and make accessible timely and quality CE.

Along with promoting quality and current Continuing Education, the AOA is committed to CE standards and practices for optometry that support our profession’s considerable advocacy gains of the last 40 years. This means that standards and practices of developing, accrediting and evaluating optometric CE that are different from the models currently utilized in the mainstream of health care must be transitioned into methods consistent with our colleagues in the rest of healthcare. As optometry continues its path towards full integration into the healthcare system, it is imperative that we eschew standards and practices that “look different” to mainstream healthcare because it perpetuates the isolation of optometry within the larger healthcare system.

The AOA believes that while it is very important to look at CE with all of the stakeholders of the profession in mind (and not merely through the eyes of certain groups within the profession), it is additionally vital that we look at Optometric Continuing Education in the context of healthcare in general and how other healthcare professions are meeting or have already met the challenges we see before us.

Accordingly, as in medicine, Continuing Education of the future needs to promote evidence based optometry. Clinical practice guidelines, keys to setting standards of care in the past, are being replaced with evidence based guidelines and Optometry must understand and adapt to those changes. Continuing Education must reflect those changes.

Further, Continuing Education of the future needs to be independently accredited by an agency agreed upon by all stakeholders within the profession yet recognized as a valid accrediting body outside the profession. And that accreditation needs to be primarily granted to providers of Continuing Education.

Currently, optometry’s Continuing Education model does not incorporate any of the criteria just mentioned.

Finally, no profession is currently advocating for the addition of mandatory measures for relicensure either through continuing education or other assessments. Once again, the AOA believes that optometry must examine solutions already accepted by mainstream health care. The AOA strongly believes that mandatory measures for relicensure for optometry is unnecessary and threatens the license (and therefore the livelihood) of doctors inappropriately without any evidence that any improvement in quality of health care would be provided to the public.
THE ASSOCIATION OF SCHOOLS & COLLEGES OF OPTOMETRY (ASCO)

National Optometric Continuing Education Conference
April 27 – 28, 2013
Rosemont, IL

Background: Founded in 1941, the Association of Schools and Colleges of Optometry (ASCO) is a non-profit education association representing the interests of optometric education. ASCO’s membership encompasses the schools and colleges of optometry in the United States and Puerto Rico. Several international optometry schools are affiliate members.

ASCO is committed to supporting excellence in optometric education and to helping its member schools prepare well-qualified graduates for entrance into the profession of optometry.

Mission Statement: The mission of the Association of Schools and Colleges of Optometry is to serve the public through the continued advancement and promotion of all aspects of academic optometry.

In support of this mission, the Association of Schools and Colleges of Optometry is committed to fulfilling the leadership role in the optometric education enterprise by:

- Serving as the advocate and spokesperson at the national level;
- Providing leadership in education policy and research;
- Supporting member institutions in the advancement of common goals;
- Encouraging and facilitating interaction and cooperation among member institutions;
- Serving as a liaison to the larger community of optometric organizations, health professions education associations, other health care professions and industry;
- Promoting ethnic and cultural diversity and by supporting member institutions’ embrace of diversity in their practices and programs as it embodies the idea of an open and multicultural society; and
- Supporting the international development of optometric education.

Overview of the role of ASCO: Notably the mission of ASCO is broad-based as are the missions of its member institutions. Like most higher education programs in the United States, ASCO members generally view their educational obligations as extending well beyond doctor of optometry (OD) degree programs and may be engaged in the delivery of post-graduate residency programs, fellowships, graduate-research (MS, PhD) and other complementary degree programs, advanced graduate certificate programs, continuing medical education and practice amplification programs in response to changes in scope of practice. A common phrase in higher education is
“cradle to grave”, which recognizes that education is a life-long process and degrees are just one marker in that process: it is a phrase that is particularly applicable to health professionals. ASCO and its member institutions provide the profession with academic expertise. They serve not only as a source of knowledge (content), but as experts in process (teaching and learning) and perhaps as critically in developing, defining and assessing competency. ASCO’s role as a source of academic expertise is reflected in its nomination of individuals (dean, presidents or faculty) to other educationally linked organizations including the Accreditation Council on Optometric Education (ACOE), the National Board of Examiners in Optometry (NBEO) and the American Board of Optometry (ABO). All are focused on assessment and quality assurance, with the first looking at educational programs and the latter two being focused on the individual student/provider.

ASCO is also directly responsible for the development of the Optometric Admissions Test (OAT), the coordination of the national centralized application program (OptomCAS) and most recently assumed oversight of optometry’s residency matching program (ORMatch).

**Role of ASCO in establishing competency standards:** Every state in the country requires that for candidates to qualify for licensure they must have graduated with a Doctor of Optometry degree from an ACOE accredited institution. To be awarded accreditation (among many other requirements) the Doctor of Optometry degree program must have a defined set of clinical competencies against which each student must be assessed and have successfully demonstrated in order to graduate. At this time, with it being possible for students to have completed all parts of the national board half-way through their final year of optometry school, the decision to graduate a student generally represents the final assessment of the student prior to licensure.

ASCO served as the coordinating body through which a common set of standards was developed. First published in 2000 and updated in October 2011, the ASCO Report - *Attributes of Students Graduating from Schools and Colleges of Optometry*, provides a uniform set of competency statements reflecting standards of knowledge, capabilities and professionalism required for graduation. Similar competency statements exist for all doctoral health professions and take into account scope of practice statutes nationwide. This document also lays out assumptions including:
• Doctors of Optometry are responsible for ongoing self-learning and for remaining current and competent in their knowledge and skills.
• The new graduate must also recognize that the completion of the Doctor of Optometry degree program is only the first step in a life-long commitment to self-directed learning and continual professional improvement.
• Each graduate will possess personal attributes such as a commitment to life-long learning and providing the highest standard of care.

The emphasis on competency-based outcomes among health care professions educators, allows for a shift away from traditional lecture-based teaching by recognizing there are many different ways to teach and to learn. The updated report was sent to every state board of optometry President and it is available on the ASCO website, www.opted.org.

Role of ASCO in Continuing Medical Education & Quality Assurance: Every optometry program provides continuing education, but to varying degrees. ASCO as an association has served to facilitate inter-institutional dialog through its Special Interest Group (SIG) structure. An ASCO SIG, consisting of the Continuing Education Directors, from each program, collaborate and meet on an annual basis to discuss issues of mutual concern.

At its annual meeting in June 2012, the ASCO Board of Directors did have an extended discussion about the issue of accreditation of CME which resulted in motion supporting the development of an accreditation process. Several principles highlighted the discussion, including:

• The provision of high quality continuing education is paramount to life-long learning among doctors of optometry.

• Currently, accrediting agencies and processes of accreditation which are recognized by the United States Department of Education (USDE), the Council on Higher Education Accreditation (CHEA) or similarly independent organizations, reflect the highest standard for quality assurance in education, including within the health professions, in the United States, as such;
  • Recognition by nationally-recognized, independent organizations requires the accrediting agency to demonstrate compliance with national standards for accrediting agencies; and
- Formal recognition requires accrediting agencies to demonstrate that they are independent and free of conflicts of interest which could compromise prudent and judicious reviews of educational programs.

- The Accreditation Council on Optometric Education is recognized by the USDE and CHEA, and has a long history of providing the profession of optometry, and its schools and colleges of optometry, with accreditation services of the highest integrity and quality and thus could be an appropriate agency to take on the accreditation of continuing education. If another agency were formed to provide for the accreditation of continuing medical education in optometry, it should be held to similarly high standards.

- The profession of optometry currently has no nationally recognized accreditation process for continuing education; implementing one should increase congruence with other health professions and enhance the effectiveness of continuing education in enhancing patient care outcomes.

**ASCO Endorsement of CME Accreditation:** Based upon these principles the Board of Directors of ASCO on June 26, 2012 passed a motion\(^1\) supporting the development of a federally/nationally recognized accreditation process for continuing education programs in the profession of optometry. The motion also stressed the need for 1) profession-wide participation in the development of accreditation standards and 2) a comprehensive business plan, taking care to insure there are adequate resources to support an accreditation of continuing education process that will be of the highest quality before proceeding.

While not explicitly noted in the motion, the conversation about and motion to endorse the development of a process for accreditation of CME, assumed that the process would be provider-based and not course based. In this regard, the definition of “provider” is meant to represent “a range of organizational types [not individuals] which offer CME to national or international audiences of health care professionals.”\(^2\)

**Note:** This paper was developed by Dr. David Heath, President of ASCO and reviewed by members of the ASCO panel and ASCO Executive Committee. It has not been formally endorsed by the ASCO Board of Directors.

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\(^1\) This action was disseminated via the ASCO Newsletter “Eye on Education”, summer 2012 issue.

\(^2\) Modified from ACCME Glossary, January 2012
National Optometric Continuing Education Conference

April 27-28, 2013
Rosemont, Illinois

National Board of Examiners in Optometry; the continuum of life-long learning, continuing education, and continued professional development in optometry

The National Board of Examiners in Optometry (NBEO) was founded in 1951 by the Association of Regulatory Boards of Optometry (ARBO), the federation of state optometric licensing boards in the U.S., and the Association of Schools and Colleges of Optometry (ASCO), the association of optometric educational programs in the U.S. and Canada. The creation of the National Board was based on the need for entry-level knowledge and skills assessments which state boards could accept in lieu of their own examinations for licensure to practice optometry. Throughout its 62 years of service to the profession and the public, the NBEO has worked to gain the confidence of the state boards as the single pathway to licensure. Today, the National Board is established as an integral element in the assurance of competence for licensure.

Through the credibility of its credentials, optometry has earned, and wishes to maintain, the respect and trust of the public and other healthcare professions. This credibility comes from a combination of the quality, scope, and depth of the professional education received during the 4-year professional curriculum; the optometric and psychometric rigor of the National Board examinations used for licensure; and the legitimacy of the continuing education (CE) undertaken throughout one’s professional career.

The latter issue is particularly important and arguably underdeveloped in formality (e.g., courses, tracking, assessing) in relation to that of other professions and American National Standards Institute (ANSI), and the National Commission for Certifying Agencies (NCCA). This is especially true in relation to the explosion of knowledge that has lead to a reorganization and expansion of contact time (i.e., summers) within the 4-year curriculum at the academic institution; the restructuring of the NB examinations; and the establishment of the National Center of Clinical Testing in Optometry (NCCTO). In addition, an increasing appreciation for the benefits of post-graduate residency training has led to a need for advanced competence assessment in the form of the NBEO-developed Advanced Competence in Medical Optometry (ACMO) examination.
The Mission of the NBEO is:

*To serve the public and the profession of optometry by developing, administering, scoring, and reporting results of valid examinations that assess competence.*

This is a logical mission statement as the National Board is the profession’s testing agency, and the profession is dedicated to protecting, maintaining, and enhancing the vision and eye health of the public. As an independent health profession, optometry must continually evaluate itself and the needs of the public:

- Are new diseases and conditions and a better understanding of their underlying pathologies emerging?
- Are new ophthalmic, pharmaceutical, and surgical therapies being created?
- Are new and improved diagnostic technologies being embraced?
- What new knowledge is needed to keep abreast of these vital developments?
- As new knowledge does not replace existing knowledge but rather is additive, how can flexibility within the current 4-year post-baccalaureate professional education and training programs be achieved to accommodate the related additional curriculum content?
- As optometry confronts an explosion of knowledge that has pushed the 4-year academic program to its limits, will the assessment mechanisms of the National Boards need to be extended beyond the current (restructured in 2009-2011) 3-part exams?

It is clear that the entire profession is challenged by change, not just the schools and colleges, not just the state boards, but the national organizations that support them. The National Board, through its assessment model and credibility, stands ready to help the progress in documenting for the public that the profession has maintained and enhanced its base of knowledge and skills to continue to provide contemporary, competent eye and vision care.

The Council on Optometric Practitioner Education (COPE) of ARBO successfully has been accrediting continuing education programs for state boards and providing a “seal of approval” for practitioners. As a related issue, the ongoing improvements to the ARBO data bank led to a vastly improved and redesigned ARBO website which has facilitated OE TRACKER and COPE in providing enhanced services to the state boards and profession. The National Board has partnered with ARBO in making the initial assignment of OE TRACKER numbers to those candidates taking NBEO examinations.

Because of its unique perspective and expertise in assessment, the National Board has earned the respect and confidence of the schools and colleges (and thereby ASCO) and the state boards (and thereby ARBO). While not a direct participant in the CE efforts of optometry, as its Mission defines, it is focused on competence and its assessment. The National Board is uniquely well-positioned to assist in enhancing the benefits of CE and to help target it to those practitioners who most would benefit from enhanced tracks of CE.

It is incumbent upon the profession and the efforts of state boards to assure that the outcomes of programs purported to transfer new knowledge and skills to practicing...
doctors of optometry (i.e., CE) are appropriately evaluated using industry-wide psychometric standards. The professional psychometric standards applied by the National Board in assuring entry-level competence have stood the test of time and outside opposition. These professional standards are based on the guidelines of numerous standard-setting agencies and organizations in which the National Board has been active in the development and promotion of these standards throughout the testing industry.

As all interested organizations consider the future development of CE, there is a specific role for the National Board as a resource to the state boards and profession. The NBEO is able to assist in assessing CE efficacy through continuing education with examination (CEE). This process will assure that the measurement by CE providers of new knowledge gained, and/or new skills acquired, is carried out according to accepted professional psychometric standards. With this design, the designation “COPE-Qualified” can be awarded if the assessment element of the course lives up to the assigned professional psychometric standards.

In other words, if the evaluation of new knowledge gained, or new skills acquired, is a part of the continuing education requirements for license renewal, those providers developing the associated assessment instrument (CEE) should be expected to adhere to the same professional psychometric standards adopted by the state boards for initial licensure, through their acceptance of National Board examinations.

The only measure of continued competence that currently exists is the fairly universal requirement for a certain number of hours of continuing education that has been adopted by the states as part of the profession’s commitment to protecting the public through the state licensing acts. To some extent, COPE provides a level of assurance that courses presented at national and regional meetings actually do meet some minimal standards of acceptability in terms of course structure and administration. Although relatively few courses require an assessment of the knowledge gained from the courses (CEE), they have been strengthened by the establishment of reasonable and non-onerous standards for the examinations that follow each unit of education.

The need for assuring continued competence is an inherent professional obligation that has driven the profession to install mechanisms for such a demonstration that occurred with the expansion of the scope of practice to include the use of drugs for diagnostic and therapeutic purposes (the NBEO TMOD examination). In addition, the profession has demonstrated its recognition of this need by establishing mandatory continuing education requirements for license renewal at the state level. From the public perspective, the issue is more one of identifying “incompetence” than documenting gradations of competence. Continued professional development in optometry (CPDO) can be demonstrated through a number of vehicles including an assessment of knowledge and skills gained from continuing education programs.

In all cases, the measurement or demonstration of continued competence must be done in a way that stimulates a practitioner to achieve life-long learning. This is best regarded as a process that offers a superior level of service to patients rather than as a means to deny practice privileges to an already licensed optometrist.
Accredited Continuing Optometric Education: Supporting Improvement in Knowledge, Performance, and Patient Outcomes for the Public Welfare

ARBO’s Perspective on Practitioner Continued Competency Assurance
National Optometric Continuing Education Conference
April 27-28, 2013
Rosemont, IL

Background

The Association of Regulatory Boards of Optometry (ARBO) is a 501(c)(3) organization founded in 1919 for the purpose of creating a forum for sharing information of mutual interest among state boards of optometry. While ARBO’s scope of activities, like any other organization, has continued to evolve from this simple beginning, our current mission statement addresses much the same audience and serves much the same purpose as in 1919: The mission of the Association of Regulatory Boards of Optometry is to represent and assist member licensing agencies in regulating the practice of optometry for the public welfare. Simply put, our purpose is to serve our member Boards

The Licensing Boards of Optometry

Licensing boards of optometry are governmental agencies charged with regulating the practice of optometry within a legal jurisdiction and are solely accountable to the public. The primary function of an optometry regulatory agency is to promote public safety by assuring that the applicants have met the entry-level competency requirements for initial licensure. Beyond initial licensure, optometry regulatory agencies are charged by law to regulate and require continued competency of these practitioners throughout their career. The regulatory agencies may otherwise restrict or remove the license of an optometrist should the board come to believe the public is endangered. It is at each agency’s discretion as to where the competency levels for both initial and continued licensure are established. No other group in optometry is similarly empowered.
Development of COPE

In 1991, ARBO was challenged to assume a leadership role in improving the current competency standards of practitioners for licensure renewal. In response, ARBO established the Continuing Competency Assessment Committee (CCAC), comprised of representatives from ARBO, AOA, ASCO, and the American Academy of Optometry (AAO). After consideration of several concepts to improve practitioner competency, the committee decided to improve the quality and accountability of the CE system. The work product of this committee became the Council on Optometric Practitioner Education (COPE).

Before COPE, individual licensing boards reviewed and approved every CE course prior to presentation. The multitudes of approval processes were non-standardized, resulting in a system that was inefficient, redundant, inconsistent, and labor intensive. CE providers often had to do duplicate work and optometrists with multiple licenses were often confused as to the specific CE required for license renewal in each jurisdiction. The burden of proof was on the practitioner to contact each regulatory board to determine if a course would be acceptable for maintenance of licensure (MOL).

The initial COPE program was designed to address these issues. A thorough review of state laws resulted in the formation of a set of criteria that was an amalgamation of all state CE requirements. These standards generally meet or exceed the regulations of all jurisdictions. CE regulations have continued to change with expanding scope of practice and requirements for federal accountability. COPE standards have also continued to evolve to meet the needs of a continuously changing environment.

COPE: A CE Accrediting Agency

The 1992 ARBO CCAC report stated that the work product of the committee was intended to be an accreditation agency: “Realizing that optometrists have a responsibility as a health professional for life-long learning; that licensing boards have a responsibility delegated by the state for the visual welfare of the public; and that licensing boards are therefore responsible for the continuing competence of all licensed practitioners, then it seems readily apparent that accreditation be applied to
CE as it is to initial education.” In 1993, the ARBO House of Delegates passed a resolution authorizing the formation of COPE. The language of the resolution stated: “Whereas, prior efforts to implement the accreditation and certification of continuing education have been unsuccessful in the past; . . . now therefore, be it resolved, that the ARBO member boards support the Council on Optometric Practitioner Education by taking appropriate action to accept COPE approved courses as needed for each member board’s requirements.”

In June 2008, the COPE Committee recommended that the Mission Statement and COPE objectives be updated to more accurately reflect the intention of the original committee and to represent the true function of the COPE process. The COPE standards had matured and gained widespread acceptance within the optometric community. It was the committee’s assertion that the term, “accreditation,” more accurately defined the COPE process of establishing standardized criteria for quality optometric CE. The change in terminology from COPE approval to accreditation was presented to the ARBO House of Delegates in Washington, DC during June 2009.

Quality Improvement of COPE-Accredited CE

COPE’s standards for accredited CE have advanced over time to meet the changing needs of the regulatory boards and the profession. The COPE accreditation criteria must continue to evolve by addressing the competence and performance gaps of optometrists to improve patient care and address the public’s increasing demands for accountability. There are several key points that should be addressed to create an environment of quality improvement in optometric CE.

COPE-Accredited CE should be linked to practice and focus on health care quality gaps.

In other words, accredited CE providers should state their missions in terms of changes in competence (“knowledge in practice”), performance (the actions taken), and patient outcomes resulting from their CE. CE content should match the scope of the optometrist’s practice, activities should be linked to practice-based needs, and changes in OD competence or patient outcomes should be
COPE-Accredited CE should be independent of commercial interests.
COPE’s Standards for Commercial Support require that all COPE-Accredited CE be free of commercial bias and independent from commercial interest in topic selection, planning decisions, and presentation content. Simply stated, the public demands that CE be of demonstrated value, support innovation and new technology and free of commercial influence.

COPE-Accredited CE should support optometrists in maintenance of licensure (MOL).
Regulatory jurisdictions of optometry require ODs to complete CE to retain their licenses to practice. Every state in the US has acknowledged the value of COPE-Accredited CE to some degree. Maintenance of licensure through fulfillment of continuing education requirements implies that CE credits alone are sufficient for professional competency and public protection. To be effective, continuing education must be planned, structured, delivered, and measured in a manner to support this endeavor.

COPE Accredited CE should support optometrists as they complete their own personalized maintenance of certification (MOC) processes.
Board certifications and certification maintenance programs for optometry have been developed. Accredited CE providers should be positioned to support ODs as they complete board certification and MOC programs. COPE-Accredited CE should support such efforts. Continuing education is a critical asset to the MOC process. In order to maintain validity and credibility, CE course accreditation processes should reflect the content and integrity expected by the public.
COPE-Accredited CE should foster collaboration to address quality improvement.

COPE and Accredited CE providers should strive to utilize modern models of learning by providing outreach, education, and coordination to nurture innovation and interaction among stakeholders. Parallel to continuing medical education outcome measures, COPE accredited CE should strive towards higher levels of outcomes. Learning alone is not sufficient. Competence and performance measures are good, but ultimately, patient health and community health outcomes should be sought.

Summary

Optometrists rely on continuing education in order to continuously improve patient care. Such CE must be tailored to meet the needs of ODs and their patients. In addition, CE is utilized not solely for MOL, but also for maintenance of board certifications in optometry. COPE-Accredited CE must be free of commercial influence. CE Providers should incorporate a continuous Quality Improvement program to measure improvement in performance and patient outcomes. Innovations in education and interactions among stakeholders should be encouraged. Given the expectations of an increasingly demanding society and the increasing knowledge base of optometry, it’s crucial that CE successfully supports increased knowledge of practitioners, improvements in practice performance, and improvements in patient outcomes.