A Strategic Framework for Optometry and Optometric Education

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Abstract

The following slide presentation describes an eight step plan to comprehensively restructure the profession of optometry to meet the expectations of private, Federal and State insurers, external certifying agencies, and credentialing and privileging boards by placing optometry in parallel with medicine.

Significant changes to optometric education, clinical training, licensure requirements, board certification and accreditation are described (1) to qualify optometry for inclusion in the Graduate Medical Education Residency Program (GME), a $10 billion annual program which currently funds post graduate training for physicians, dentists and podiatrists, and (2) to meet Federal insurance compliance guidelines for teaching programs. Recommendations to decrease optometry student debt are also included.

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Forward

- **"We must not let anyone else write our future."**

  Dr. Ronald Hopping, President, American Optometric Association, June 2012.
- In the absence of a strategic plan for optometry, an eight step framework is recommended.
- The proposed plan is politically challenging with numerous sensitive professional and educational issues.
- There is no easy path if optometry is to maintain a strong position in a rapidly evolving and third party dominated health care system.

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Restructure the Profession of Optometry

- **Comprehensively restructure the profession of optometry and optometric education including pre-optometry and core professional curricula, postgraduate training, licensure, board certification, maintenance of certification and accreditation by placing optometry in parallel with medicine.**
- *Restructuring of optometry and optometric education will be a long term, evolutionary process similar to the introduction of pharmaceutical agents.*

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Achieve Synergism

- **The eight step framework is designed to facilitate synergism among state licensure requirements, optometric curricula, postgraduate clinical training, board certification, maintenance of certification and accreditation.**
- *Action plans for <u>each step</u> would be developed by representatives from relevant optometric organizations. Specific organizations noted on the following slides.*

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Meet Expectations

- **Optometry must be prepared to meet the expectations of private, Federal and State insurers, health care consumers, prospective optometry students, external certifying agencies, credentialing and privileging (C&P) boards, and Federal health professions education programs such as the Graduate Medical Education Program (GME) and the Department of Veterans Affairs (VA).**

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Step One

- **Require one year of mandatory postgraduate (PG) clinical training for state optometric licensure.**
- *Currently, there is no mandatory postgraduate training required for state optometric licensure with the exception of Arkansas and Delaware.*
- *Requiring (PG) clinical training for licensure would serve as the catalyst for transformation to the medical model.*

***(*ARBO,** State Societies **)**

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Step Two

- **Restructure the optometric curriculum by awarding the Doctor of Optometry (OD) degree after three years and reclassifying the 4th year as the first year of residency.**
- *Re-designate current 4th year externship rotations as General Optometry (PG-1) residencies.*
- *The length of optometric education to enter practice remains 4 years (3 years + 1 PG year), and positions optometry for inclusion in GME.*
- *Current optometric clinical training is not compatible with Federally supported patient care and clinical training programs.*

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*(**ASCO**,AOA)*

Step Three

- **Adjust National Board of Examiners in Optometry (NBEO) examination process to accommodate the new curriculum, mandatory postgraduate clinical training and board certification.**
  - *Ensure NBEO and Certification Boards examinations and certification processes are compatible.*

(**NBEO**, Certification Boards)

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Step Four

- **Require one year of postgraduate (PG) clinical training for board certification in General Optometry.**
  - *Two years of PG training required for board certification in specialties and three years of PG training for sub-specialties.*
  - *Synthesize the American Academy of Optometry's (AAO) diplomate classifications with Association of Schools and Colleges of Optometry (ASCO) residency classifications and place in specialty and subspecialty categories.*

(**AOA,**ASCO,AAO)

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Step Five

- **Set consistent standards among various certification boards by establishing an oversight board analogous to medicine's American Board of Medical Specialties (ABMS).**
- ***Designate the oversight board as the American Board of Optometric Specialties (ABOS).***
  - *There is an immediate need for the (ABOS) as several certification boards are currently in place and applying varying standards.*

(ACOE.ABO,ABCMO,COVD, other certification boards)

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Step Six

- **Only postgraduate clinical training programs accredited by the Accreditation Council on Optometric Education (ACOE) would be recognized for board certification.**
  - *ACOE is analogous to medicine's Accreditation Council for Graduate Medical Education (ACGME).*

(ACOE)

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Step Seven
Parallel with Medicine

- **With completion of steps 1-6, optometry would be parallel with medicine and consistent with current and anticipated Federal/State health care policies, private insurers and health care consumers expectations, external certifying agencies, credentialing and privileging boards, and requirements for participation in Federal health professions education programs.**

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Step Eight

- **Initiate Federal legislative and Health and Human Services (HHS) Departmental advocacy to include optometry in the Graduate Medical Education (GME) program.**

(AOA,ASCO**)**

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Why Restructure the Profession of Optometry?

- **Rather than systemic restructuring of the profession in accordance with a comprehensive strategic plan, changes to optometric practice laws and Federal/State current and anticipated health care policy have been addressed:**
- *By incremental changes to state licensure requirements, clinical education, postgraduate training and board certification.*
- *Consequently, unaddressed structural issues persist and weaken optometry's position as a major provider of eye/vision care in a third party dominated health care system.*

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Board Certification & Specialty Recognition

- **Currently there is no nationwide acceptance of optometric postgraduate specialty training, board certification and maintenance of certification.**
- *Since optometrists are classified as physicians under Federal law, they will be judged utilizing the medical model as the standard including board certification and maintenance of certification.*
- *Multiple certification boards, as in medicine, can exist as long as an oversight board (ABOS) is in place to ensure consistent standards.*

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Board Certification & Specialty Recognition

- **Current external recognition of existing certification boards:**
  - *The American Board of Optometry (ABO) is accredited by the National Commission for Certifying Agencies (NCCA) and recognized by (CMS) for PQRS bonus payments.*
  - *And the American Board for Certification in Medical Optometry (ABCMO) as a certifying agency by the Joint Commission on Accreditation of Health Care Organizations (JCAHO).*

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Why Restructure Optometric Education and Clinical Training?

- **Optometry does not require postgraduate (PG) training for entry-level practice nor (PG) training for board certification, and therefore is not eligible for GME support.**
  - *Unlike medicine and podiatry, optometry's clinical training is contained within the core four year curriculum.*
  - *Dentistry has specialty certification boards, including board certification in General Dentistry.*
  - *GME only funds postgraduate training.*
  - *Annual expenditure on optometric clinical training is over $100 million.*

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Why Restructure Optometric Education and Clinical Training?

- *Current optometry "residents" are not recognized by U.S. Department of Health and Human Services (HHS), because they do not meet GME criteria.*
- *Places emphasis on clinical training.*
- *Optometry does not receive Federal funds to compensate for cost of clinical training inefficiencies and overhead costs.*
- *Federal insurance compliance vulnerabilities persist in all clinical training venues as students are restricted from providing billable services.*

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Three Year Optometric Curriculum

- **Award the O.D. degree after three years and re-designate the current fourth year as the first year of residency in General Optometry.**
- *A three calendar year curriculum is possible by: removing course redundancies, moving more material to pre-optometry requirements and fully utilizing distance learning capabilities.*
- *A major paradigm shift is also required where clinical faculty (preceptors) are in charge of the patient rather than in charge of 2nd and 3rd year optometry students in order to meet Federal and most private insurance compliance guidelines.*

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Three Year Optometric Curriculum

- *With a three year curriculum and GME and VA stipends, student debt could be reduced by $30,000 to $50,000 or more.*
- *Loss of 4th year tuition revenue and reforming the curriculum are difficult short term issues for all optometry schools*
- *Even though prestigious medical schools such as New York University are offering three year MD programs, political concerns about comparisons with traditional 4 year medical and dental programs persist.*

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What is GME?

- **The Graduate Medical Education Residency Program (GME) is the educational component of Medicare, and provides $10 billion annually to support postgraduate clinical training for physicians, podiatrists and dentists.**
- *GME pays an average of $100,000 annually per medical resident to hospitals.*
- *Optometry is not eligible for GME because its clinical training model, licensure requirements and board certification do not meet GME expectations.*

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What is GME?

- *Seeking GME support for current "residents," while leaving the curriculum at four years would provide support for only 180 private sector optometry residents even if eligible.*
- *A three year curriculum plus one year of residency would potentially provide Federal (GME & VA) support for as many as 1700-1800 trainees.*
- *GME payments will be made to the clinical entity and not an optometry school. A separate legal structure for campus-based clinics is required.*

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Benefits of GME

- **Infusion of millions of dollars of Federal support would have a significant and lasting impact on optometric education.**
- *Optometry residency programs would be eligible for Direct payments (salaries, stipends & other overhead).*
- *And also Indirect payments, based on the complexity of the case, for hospital based optometry residents.*
- *Current "residents" would become postgraduate (PG-2 & PG-3), would be recognized by HHS and also eligible for GME.*

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Benefits of GME

- *Reduction in student debt.*
- *A significant increase in available resident positions would likely result as GME funding increases the attractiveness of optometric residency programs at academic medical centers, hospitals, community heath centers and other health care facilities.*
- *Enhances the prestige of the profession.*

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Patient Care Accreditation

- **Accreditation of optometric patient care facilities by the Joint Commission on Accreditation of Health Care Organizations (JCAHO) or similar organization will likely be required for participation in Federal programs.**
- *Accreditation by JCAHO of postgraduate and student clinical training sites would also assure ACOE of quality patient care and adequate patient volume and for clinical training.*

(**AOA,**ACOE,ASCO)

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Compliance with CMS Teaching Guidelines

- **Compliance vulnerabilities with the "Center for Medicare/Medicaid Services (CMS) Guidelines for Teaching Physicians, Interns and Residents" persist in all optometric clinical teaching venues, including externship sites.**
- *Because optometric students are restricted by Medicare/Medicaid regulations from providing billable services.*
- *Students can only take/record Review of Systems and Family/Social History.*
- *Any contribution of an optometry student to a service must be performed in the <u>physical presence of a physician</u> or jointly with a resident.*[27]

Compliance with CMS Teaching Guidelines

- *Residents may provide billable services jointly with the billing physician if properly supervised.*
- *Private health care insurers also apply CMS regulations.*
- *Enforcement of all CMS regulations and teaching guidelines will likely increase with the implementation of the Affordable Care Act (ACA).*
- *Heavy fines will continue to be levied for violations of CMS Teaching Guidelines.*
- *Internal routine audits are prudent. If violations are discovered, <u>Self Reporting</u> will potentially prevent higher fines and more severe penalties.*[28]

Department of Veterans Affairs

- **The VA has the largest optometric clinical training program in U.S. providing training opportunities for 1400 students, 186 residents & 3 fellows with 1.5 million patient visits annually.**
- *With 3 year curriculum, current 4th year students would be converted to PG-1 residents and current VA residents & fellows become PG-2 and PG-3.*
- *Podiatry successful in securing additional funded VA residents when they changed their clinical training model and state licensure requirements to the medical model in the 1980's.*

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Department of Veterans Affairs

- *New optometry clinical training model, mandatory PG training for licensure and board certification would ensure future VA funding.*
- *Veterans Affairs (VA) supported residents are not eligible for GME.*
- *However, all residents (PG-1,2,3) would be eligible for stipends paid directly by the VA or through affiliation agreements with sponsoring optometry schools and colleges.*

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Clinical Training Costs and Student Debt

- **Introduction of advanced clinical procedures and expanded use of pharmaceuticals increase clinical training costs.**
  - *These and other increasing costs are passed on to the optometry student in the form of higher tuition and debt.*
  - *Unlike medical residents, who are paid stipends, 4th year optometry students do not receive stipends, and furthermore pay tuition during their final clinical year.*
  - *Optometry student debt is excessive, averaging $140,000-$175,000. Over $200,000 for some.*

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Student Applicant Pool

- **High educational debt compared to potential annual median income of $94,990 is a major contributing factor to the decline in the optometric student applicant pool.**
  - *There is only one qualified applicant for each entering seat.*
  - *A decline in the U.S. birth rate and proliferation of new optometry schools exacerbate the problem.*
  - *Recent graduates report employment opportunities are mostly part-time, requiring practicing at multiple locations.*
- *Optometry is not eligible for Federal educational debt repayment programs, e.g. (NHSC).*

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Fast Track to MD
Why Not Fast Track to OD?

- **Adopt a less costly, more efficient overall educational model, requiring a minimum of 6 years after high school for licensure and board certification in General Optometry.**
- Expansion of accelerated admissions to optometry schools and a 3 year curriculum + 1 (PG) training program would significantly reduce educational debt.
- *Eight U.S. medical schools have or are developing 3 year programs: Mercer, Erie Osteopathic, Texas Tech, Louisiana Tech, Indiana, Tennessee State, Kentucky and NYU.*
- *Some medical schools offer accelerated admissions after 90 college credit hours.*

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Recommended Actions by AOA, ASCO and ARBO

- **AOA, ASCO, ARBO with the cooperation of AAO,NBEO, ACOE, Certification Boards NAVAO,AFOS and AOSA collaboratively reach consensus on mandatory postgraduate clinical training for licensure, a three year curriculum, specialization, accreditation, board certification, maintenance of certification and compliance with CMS Teaching Guidelines.**
- *Commit the energy and resources necessary to develop, execute and monitor the implementation of a long range, comprehensive strategic plan for optometry and optometric education.*

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Optometric Manpower Issues

- **Accurate data are needed for long range planning and legislative advocacy.**
  - *Abt Study in 1999 predicted a surplus of optometrists.*
  - *Bureau of Labor Statistics (BLS) is now projecting a 33% increase in demand for optometrists or 11,300 additional by 2020.*
  - *Proliferation of new optometry schools at time of declining student applicant pool.*
  - *Lewin Study to reconcile disparity.*

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State Legislative Advocacy

- **State optometric licensing laws amended to include:**

  "One year of postgraduate clinical training in a program accredited by the Accreditation Council on Optometric Education (ACOE), leading to board certification is required for licensure."

(**State Societies**, ARBO)

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Federal Legislative Advocacy

- **Federal legislative and (HHS) Departmental advocacy advanced to amend the Social Security Act to include optometry in GME.**
- **Legislative and direct VA advocacy initiated to fund new optometric residents (PG-1), formerly 4th year externs.**
- *GME payments to hospitals expanded to include optometric clinical training venues such as outpatient clinics, community health centers and group practices.*
- *Podiatry successful in amending the Social Security Act in 1972 to include funding for podiatric postgraduate training.*

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(**AOA,** ASCO, AOSA, NAVAO)

Yes, These Are Bold Steps, But So Were:

- Expansion of clinical training to community health centers, Federal facilities and medical facilities in 1969.
- Introduction of pharmaceuticals and advanced clinical procedures into optometric practice in 1972.
- Creation of the VA Optometry Service in 1976, now providing 1.5 million eye visits, training for 189 residents and 1400 students.
- Inclusion of optometry in Medicare in 1987 with over $1.0 billion in patient services and CMS incentives now provided annually.

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Yes, These Are Bold Steps But So Were:

- Development of affiliations between optometry colleges and medical schools in 1988 & 1997.
- Development of board certification for optometrists in 2009.
- Broad-based inclusion of optometry in the Affordable Care Act (ACA) in 2012.

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