EDITORIAL

THE ACCESSIBILITY OF BEHAVIORAL OPTOMETRY

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This begins a series of columns that will periodically address factors that I believe are central issues in behavioral optometry.

When I was a professor of optometry at Northeastern State University-Oklahoma College of Optometry, I maintained a private practice plan within the college. It was a referral only, behavioral vision/vision therapy (VT) practice. Patients were seen on a weekly, and bi-weekly, basis from at least five states; Kansas, Missouri, Arkansas, Texas and Oklahoma. The patients were referred by various professionals, including optometrists.

There were a number of reasons why the optometrists consulted or referred patients to me. Since I practiced in a state institution, I was required to accept health care insurance plans that other behavioral optometrists did not accept. Those patients might be referred to me for care, since the College accepted their insurance plans. In other cases, my practice was closer to the patient's home than to the referring optometrist. In rare instances, the optometrist felt the College clinic might be better equipped to treat the patient. By and large, however, care was provided for these patients because they had a need that was not being met by the optometric profession. For whatever the reason, the optometrist who, to his/her credit, identified the problem, elected to consult with or refer the patient to me. The encompassing reason behind these consults/referrals was that behavioral vision care, that makes optometry a unique profession, was not readily feasible or accessible for these patients.

I contend that behavioral care should be accessible to all. The logical questions then are:

- Why is it not accessible?
- How can we, as a profession, make behavioral optometry more accessible to the public?

Here are some thoughts on this subject:

Many newly graduated optometrists enter established professional or corporate practices that do not offer behavioral vision care. These new graduates are then exposed to practices that ignore, or negate, this valuable service. In many instances they question the place of this type of care in mainstream optometry and overall health care. Unfortunately, as a result of these initial experiences, most will likely never venture into the exciting arena of VT. But that is a subject for another day.

For the new graduates who start practices, an obvious solution to both our questions is to encourage them to offer behavioral care. Behavioral optometric practitioners naively believe that if more new graduates try VT, they will continue to offer VT in their offices. I believe that to be colossally over simplified. Certainly, we must take steps that encourage the graduate to become involved, but that is only the first of several steps. The lack of new graduates *willing* to begin their own private practice is also a subject for another day.

Some optometrists who do begin their own practices at least try to incorporate VT early in their careers. However, as they become busier with refractions, contact lenses, and diagnosis and treatment of ocular diseases, they find less time to offer the service. Some become discouraged because other professions very often offer baseless criticism of VT, and thus, the new practitioner chooses not to continue to offer the service. Both of these reasons are again subjects for another day, but suffice it to say, only a minority of new graduates who begin offering VT in their offices stay with it. It behooves the profession, and particularly behavioral optometry, to address this problem.

The challenge and the answer to both questions is for the profession to increase the number of optometrists offering behavioral optometry. In order to accomplish this, we must first demonstrate to the student and new graduate optometrist that VT is an effective modality, and that it can be successfully incorporated into the primary care optometric office. It can be done; there are primary care practices throughout the world that accomplish this very successfully. I propose that extended exposure to these successful primary care practices that offer VT would go far to encourage students or new optometrists to make VT an integral part of their practices, whatever the venue.

There has been some degree of progress for the last decade with students gaining this type of experience. My observations are that at least some of optometry's schools and colleges offer their students fourth year internships at primary care practices that incorporate VT. A number of students who elected these programs have told me how positive the experience was, and that they gained a new appreciation of the value of VT to the public and to the particular office. Optometrists who supervise these internships increasingly look forward to their roles as teachers/mentors and appreciate the recognition the optometric institution affords them. All in all,it is a win-win situation for both the student and teacher.

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I propose that more offices that provide behavioral optometric care consider becoming involved in this type of endeavor. The first step is to investigate the requirements for an office to be qualified as an extern site. One does this by contacting the particular institution's director of externships. In all instances, the policies and procedures are in the form of written documents that should be carefully read. Inherent in this policy is that schools and colleges of optometry mandate the externships to provide both clinical and didactic education. Further, there is a dual reporting mechanism; the optometrist communicates the student's progress, and the student communicates their assessment of the quality of the educational program. These reports are necessary for the optometrist's continuing appointment as an adjunct clinical faculty member at the sponsoring institution and the school's or college's mission to provide quality education for their students.

I further propose that a second method would be for the behavioral optometric community to develop office residencies. These would be for the newly graduated optometrists. These programs carry the requirement of attaining accreditation from the Accreditation Council of Optometric Education (ACOE). This process has many of the same elements as becoming an extern site for the schools and colleges of optometry, but accreditation entails a far more rigorous on going procedure. Nevertheless, it has been accomplished in optometric private offices that emphasize other areas of practice. The resident would contractually agree to meet the stated mission, goals and objectives of the program. These residencies are virtually always of a one year duration. At the end of that year, the resident would be encouraged to go to another geographic area and set up their own practice that has a significant segment devoted to the provision of behavioral optometry. Certainly, if the practice and the resident find that they are compatible, a more permanent associate or partner relationship may develop. In both instances, the ability to provide behavioral optometric care to the public would be increased.

The financial arrangements, beyond salary, would be developed by the office and educational institution according to the ACOE requirement. A key feature is that student loans are deferred during the period of the residency. The sponsoring optometrist would be required to periodically meet with the resident and teach the intricacies of conducting and administering a VT practice. A major goal of the residency would be to develop a practitioner who, upon completion of the program, has the ability to successfully start and develop a practice, or enhance an existing practice with an emphasis on the provision of behavioral optometry. In order to do this there must be a strong commitment for the resident to learn, and a clinical site to teach. The benefit to the optometric office would be that for that year, it would have a highly trained optometrist working in the office and generating income. The greater benefit however, would be to the behavioral optometric community and to society in general. This is another way that we, as behavioral optometrists, can continue to insure that behavioral optometry is not only alive and well, but that it will continue to flourish. We must solve the challenge of behavioral care accessibility.