

A Blueprint for Behavioral Optometry

As the news media reports on the progress of President Clinton's plan for reform, there is discernible anxiety among health care professionals of all types. It's as if everyone is not only waiting for the other shoe to drop, but is trying to predict whether the shoe will land upright or on its side for his or her particular field. There is the question of the future of private practice: Will it survive in the world of managed competition? Another concern relates to the timing, how many, and what kinds of networks one should join. "Shall I become a participating provider in as many plans as I can to protect my patient base now, or should I gamble, wait until the dust settles and then make my moves"? Further, there is a paradox; while many practitioners have complained increasingly about the volume of paper work the current third party system requires, the prospect of becoming part of a managed care entity that can significantly cut red tape is equally unsettling for other reasons. Apparently there is to be a trade-off. However, increased patient care accountability and decreased latitude in clinical decision making for the reward of less paper work usually does not sit well with individuals who chose a health care career for the freedom it promised.

Behavioral optometrists have two additional concerns. One relates to the strength that apparently makes optometry a candidate to play a significant role in the eventual health care delivery system; namely, our ability to provide primary eye and vision care in a competent and cost effective manner. The very real downside risk is that this emphasis rests heavily on the diagnosis and

treatment of ocular pathologies and can dilute our particular uniqueness. This is our expertise in a functional approach to the prevention, remediation, and rehabilitation of refractive, binocular and perceptual dysfunctions. The second concern is the uncertainty of whether the components of behavioral vision care will be included as covered services.

It is easy to take a doom and gloom attitude about the future and many behavioral optometrists have already assumed this state of mind. Indeed, my perception is that we, and the profession at large, have a history of not fully appreciating and consequently minimizing the contributions we make to the health of the nation. However, this is not the time for behavioral optometrists, nor the organizations that represent them, to become negative and pessimistic. It is a time to understand the current political environment, recognize our unique strengths and then use them judiciously and at the proper time. This is called strategic planning.

Consequently, the first order of business is to ensure that optometry be included at a parity level with ophthalmology for the allowed services both professions provide. This takes into account that in the current political environment probably only basic eye and vision care will be covered. It also recognizes that we have the unique strength of providing these services at least as competently and in a more cost effective manner than ophthalmology. These factors should position us as an integral part of whatever health care delivery system is developed.

The second challenge is to prove that the preventative, remediative, and rehabilitative aspects of behavioral vision care are an essential component

to maximize the health and economic welfare of the nation. The important thing to understand is that health care administrators and economists will not accept our ability to accomplish these purposes on the basis of promises. A type of research will be required that is supplemental to conventional clinical trials. Our ability to change clinical findings in a desired direction will still be a component. However, the new research initiative will be to determine whether our preventative, remediative, or rehabilitative interventions enhanced the patient's quality of life and/or were contributory to improving job performance and/or returning the patient to the work force. This might require a reallocation of our efforts and resources in terms of the patient populations we serve. It is possible that the aspirations of the health care delivery system will require less of an emphasis on our part of the learning-disabled and more on the computer operator and geriatric patient. Further, it will require a new type of alliance and communication between the clinician

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and the researcher, very much in the spirit of what Dr. Glen Steele recently wrote as the result of his attendance at the "mini summit" on research.¹

I believe that the coming winds of change will force behavioral optometrists and their organizations, the College of Optometrists in Vision Development and the Optometric Extension Program Foundation, to institute actions that are long overdue in political activity, research, education, and clinical thinking and logistics. The politics of health care will force us to institute changes we've known were necessary for a long time, but could not or would not make. These changes will eventually award behavioral optometry a secure and valued position in the nation's health care planning and delivery system.

Reference

1. Steele GT. Research and optometry. Editorial in *J Behav Optom*, 1993; 4 (4): 86.