

Private Practice Residency in Vision Therapy and Rehabilitation

Cheryl E. Ervin, OD
Barry M. Tannen, OD, FAAO, FCOVD
Leonard J. Press, OD, FAAO, FCOVD

Abstract

The concept of a private practice residency in optometric vision therapy and rehabilitation was first advocated by Dr. W.C. Maples in an editorial in the Journal of Behavioral Optometry.¹ Dr. Maples noted that although optometric residencies in this area of care have been available since the 1970s, a variety of factors have constrained accessibility to behavioral vision care in private practice. The principal focus of this paper is on the challenges faced by a private practice residency program and the goals of the program relative to the outcome for the resident, the residency site and delivery of vision therapy and rehabilitation services. Our perspective is that private practice residencies can benefit from the track record of institutional residencies, but present a unique set of attributes and considerations. Our primary purpose in presenting this information is to increase awareness in the academic and clinical communities about a new Southern College of Optometry-affiliated residency in vision therapy and rehabilitation as an option for post-graduates.

Key Words: *Optometric residency, vision therapy, vision rehabilitation, private practice residency*

Dr. Ervin is Director of Residencies at Southern College of Optometry in Memphis, Tenn.

Dr. Tannen is Residency Supervisor at EyeCare Professionals, P.C., in Hamilton Square, NJ.

Dr. Press is Residency Supervisor at The Vision & Learning Center at Family Eyecare Associates, P.C., in Fair Lawn, NJ.

The Demand for Optometric Services in Vision Therapy and Rehabilitation

There is significant need for optometric services with regard to vision and learning. As reviewed by Garzia, approximately 5% of the total school enrollment receives special educational services, with reading disability representing 80% of this population.² At least 20% of individuals with learning disabilities are thought to have a prominent visual information processing deficit, with another 15% to 20% having problems with visual efficiency.³

Similar epidemiologic need arises in the population of patients with traumatic brain injury (TBI). Because the majority of patients with TBI manifest oculomotor abnormalities, it is not surprising that difficulty with reading is a common and unmet need in individuals with traumatic brain injury.⁴ It is difficult to ascertain the precise number of doctors providing vision therapy and rehabilitation services, or the number of optometric office visits per year dedicated to these services. However, surveys estimate that there are 2 million visits per year for services related to vision therapy and rehabilitation, which includes elements of sports vision and low vision, representing approximately 4% of all visits.⁵

Another way of assessing need is by the frequency of diagnostic procedures conducted. A survey of optometrists by the National Board of Examiners in Optometry shows that behavioral vision/sensorimotor evaluations were done at a frequency of 3.7% of all diagnostic procedures.⁶ However, the same survey shows that convergence insufficiency was listed as a diagnosis in only 0.36% of the cases. Given that the prevalence of this condition is much higher in the population, and that this condition is readily amenable to vision therapy, this suggests that vision therapy conditions are underdiagnosed and undertreated.

The demand for vision therapy services is projected to steadily increase. We anticipate this is due to the success of two major research initiatives, the Convergence Insufficiency Treatment Trial

(CITT) and the Amblyopia Treatment Study (ATS). The CITT results suggest that the outcome for treatment of CI, the most prevalent type of binocular dysfunction, is considerably better with in-office therapy.⁷ This can be expected to increase the demand for optometrists with the skills necessary to provide in-office treatment services. The ATS results to date suggest that the window for treating amblyopia is at least through age 17.⁸ This effectively increases the number of treatable patients, thereby increasing the demand for doctors able to guide their treatment.

The demand for post-graduate education in vision therapy may also be linked to increased interest in board certification in optometry. Fellowship in the College of Optometrists in Vision Development (COVD) is recognized as providing a level of competency toward generalized board certification. In addition, a vision therapy residency is recognized by COVD as partial fulfillment of the requisite patient care hours required to sit for its certification examination.⁹ Over the past 10 years, the number of doctors and therapists presenting for COVD certification has been steadily increasing.

Issues in Clinical Education in Private Practice vs. Institutional Practice

The basic issues that Dr. Maples presented,¹ and our elaborations, are as follows:

- Reimbursement for patient care services through institutional residencies are often predicated on third-party reimbursement, which is not the predominant mode of private optometric practice in this field. New graduates are therefore unprepared for generating income through vision therapy services in the manner in which private practices succeed in this area of service.
- The socioeconomic profile of patients being seen in institutional practice can be considerably different than those seen in private optometric practice. For vision therapy and rehabilitation, this has significant impact on compliance, travel and other logistics that influence patient care outcomes.

- Residents in institutional practice obtain valuable experiences, but these experiences are often fragmented. A private practice residency would better position the individual to integrate knowledge and experience within the framework of primary care practice.
- New graduates are sometimes discouraged when other professionals in the community offer baseless criticism of vision therapy. An institutional resident is more shielded from these issues by the reputation of the college or university at large, whereas the private practitioner must learn to deal with these issues more directly.
- Externships in private practices that excel in delivery of vision therapy and rehabilitation services have been offered through most Association of Schools and Colleges of Optometry (ASCO) institutions, and have served the profession well. Students who have participated in these elective rotations report positive experiences in gaining appreciation of the value of vision therapy services to the public and to the practice.
- Optometrists who supervise these externships increasingly look forward to their roles as teachers/mentors and appreciate the recognition the optometric institution affords them. Being an effective preceptor requires a significant degree of commitment to education. Some sites have either provided housing or a stipend toward housing for the student.
- Externships currently require a dual reporting mechanism, with the optometrist communicating the student's progress, and the student communicating the quality of the educational program. Private practice residencies would extend this mutual commitment.
- A private practice residency seeking accreditation from the Accreditation Council on Optometric Education (ACOE) has many of the same elements required to become an extern site, but entails far more rigorous ongoing procedures. Nevertheless, it has been accomplished

in other areas of practice.

- The resident would contractually agree to meet the stated mission, goals and objectives of the program. 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 vision therapy 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 vision therapy and rehabilitation services.
- 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.
- At the end of the year, the resident would be encouraged to go to another geographic area and set up his/her own practice that has a significant segment devoted to the provision of behavioral optometry. Certainly, if the practice and the resident find 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.

In structuring a private practice residency, the sponsoring optometrist can build upon successful elements of institutionally based residencies in vision therapy. Private practice residencies should be viewed by educational institutions as providing the applicant with alternative rather than competing interests to an institution's in-house programs. As reviewed by Rouse and Appelbaum, a typical residency program is 10% didactic, 60% patient care, 10% teaching, 10% research, 5% thesis or

research paper, and 5% self-study.¹⁰ The sponsoring optometrist should be an individual with either an extensive personal library or internet-based resources through which didactic and self-study modules can be guided. This encourages the resident to develop good habits toward a life-long independent pursuit of learning. Teaching can be accomplished in several ways. If the practice is an externship site, the resident can take an active role in assisting with the preceptor's function as a clinical educator. Vision therapy practices often utilize therapists, and a teaching role can be structured around case-review and various in-service presentations. Research and other scholarly activity can be engaged through the sponsoring optometrist's affiliation with a college of optometry or other affiliations. Active involvement in organizational optometry, including attendance at key specialty meetings in vision therapy and rehabilitation, should be encouraged.

Private Practice Residency Sites in Vision Therapy and Rehabilitation

There are currently 10 recommended titles for ASCO residencies:

- Family Practice Optometry
- Primary Eye Care
- Cornea and Contact Lenses
- Geriatric Optometry
- Pediatric Optometry
- Low Vision Rehabilitation
- Vision Therapy and Rehabilitation
- Ocular Disease
- Refractive and Ocular Surgery
- Community Health Optometry.

The ASCO description of a residency in optometric vision therapy and rehabilitation indicates that the majority of the didactic and clinical curricula will be devoted to topics and practice relevant to dysfunctions of eye movement, accommodative, binocular and perceptual systems, reduced visual acuity and compromised visual fields.¹¹ The title of each residency reflects the primary focus of the clinical subject area and indicates advanced clinical education in that subject area. Some

programs choose to focus on two of the 10 areas.¹² Private practice optometric residencies in vision therapy and rehabilitation inevitably include a focus on pediatric optometry as well.

The first private practice residency program in vision therapy and rehabilitation was established by Dr. Stanley Appelbaum in 2008 in affiliation with Southern College of Optometry (SCO) under the guidance of Dr. Bart Campbell, Director of Residencies, and subsequently Dr. Cheryl Ervin.¹³ Four similar programs followed, each having the principal optometrist in the practice serving as the residency supervisor.¹⁴ The supervisor reports directly to the SCO director of residency programs, who in turn reports directly to the SCO Vice President for Academic Affairs. The current private practice residency programs are:

- **Site 1:** Vision Therapy/Rehabilitative Optometry, Appelbaum Eye Care Associates, PC, Bethesda and Annapolis, Md.
Residency Supervisor - Dr. Stanley Appelbaum
- **Site 2:** Vision Therapy Group, Sensory Learning Center, Flint, Mich.
Residency Supervisor - Dr. Bradley Habermehl
- **Site 3:** Pediatric Optometry/Vision Therapy & Rehabilitation, Child & Family Optometry, Wichita, Kan.
Residency Supervisor - Dr. Patrick Pirotte
- **Site 4:** Vision Therapy, EyeCare Professionals, P.C., Hamilton Square, NJ.
Residency Supervisor - Dr. Barry Tannen
- **Site 5:** Vision Therapy and Rehabilitation, The Vision and Learning Center at Family Eyecare Associates, P.C., Fair Lawn, NJ.
Residency Supervisor - Dr. Leonard Press.

In each of these sites affiliated with SCO, the resident is defined as an employee of the practice, and the residency stipend is paid by the practice. The stipend is in the range of \$31,000 for the year. Professional liability protection is provided by the site. Residents are

required to present credentials according to the SCO policy for credentialing of residents. The financial package for the resident is offset by revenues that the resident generates for the practice through patient care. The residents must be licensed in the state in which the practice is located, and participation in third-party care is subject to the policies of the practice for its Doctors of Optometry. Applicants must complete the SCO application forms, but need not be students at SCO to apply. The sites utilize the Optometric Residency Matching Service (ORMS) and are accredited or in the process of being accredited by the ACOE.

Residency Accreditation

It is policy at SCO that each of its residency programs be accredited by the ACOE. Accreditation verifies that educational institutions and residency programs affiliated with these institutions have attained an optimal level of educational effectiveness, integrity and quality. In effect, the process of attaining accreditation is a determinant of educational quality. In addition, many formal actions, such as governmental funding and state licensing boards, are based on accreditation status.

The accreditation process requires educational institutions and programs to conduct a self study to determine if their mission and goals are achieved, to evaluate recommendations made by an impartial site visit team, and to execute internal actions to address those recommendations. A program is evaluated during the first year in which a resident is enrolled in a program and every seven years thereafter. This periodic review requires that programs continually monitor their program and conduct assessments of the outcomes.

Once a program and educational institution form an official affiliation and enroll their first resident, a program site visit is arranged with the ACOE. Ideally, this site visit would occur several months into the residency to ensure that there is enough measurable data to analyze. Subsequently, the site visit team formulates and submits a report to the ACOE based on its findings. The ACOE then accredits a program or makes recommendations that

if implemented could result in full accreditation. The program is given a specified amount of time in which to submit a progress report to the ACOE. The entire process typically takes several months; however, once accreditation status is obtained it is retroactive to the date of the initial site visit. As a result, even though residents enrolling in a new residency program will enter an unaccredited program, they should have confidence that they will graduate from a fully accredited optometry residency program. The process of obtaining accreditation can be time-consuming for a new residency supervisor; however, full support and assistance should be expected from the affiliated institution's director of residency programs.

To assist with the residency accreditation and review process, the resident maintains an activity log to document the number and types of clinical encounters. This helps ensure a broad exposure in line with the goals of the program description. The general categories of activity are:

- **Patient encounters in any aspect of patient care:** This would include participating in or conducting parent conferences, evaluation or progress evaluation. It would also include observation or secondary or principal participation or practice management.
- **Scholarly activities in any aspect of reading and/or presenting scholarly material:** This would include articles, books, internet searches on a topic, case conferences, lunch seminars, COVID meeting activities or help in preparing articles for publication.
- **Teaching of externs or therapists related to either A or B:** This would include assistance in orienting on case programming, demonstration of procedures, and role playing of administering preliminary testing, vision therapy tests and vision therapy procedures.

SCO requires that both its residency supervisors and the residents complete quarterly online evaluations. The evaluation by the resident remains confidential so that the resident is encouraged to

critique the supervisor and the program constructively. Conversely, the online evaluation by the supervisor must be signed off on electronically by the resident to document awareness of incremental progress and areas identified for improvement in meeting the program's goals.

Conclusion

In this paper we have identified basic issues and challenges that both the residents and program supervisors face in maximizing success. As modeled by ASCO, the most successful graduates of residency programs are self-motivated, enthusiastic and hard-working. These are individuals who recognize early that what one gets out of the program is determined by what one puts into the program. Dedication, discipline, commitment and enthusiasm are required throughout the year of training. Not surprisingly, these are the qualities that characterize the practitioners who are at the vanguard of supervising the first wave of private practice residencies in vision therapy and rehabilitation.

It would be premature to encourage more practitioners to apply as site providers at this juncture. To date, only one resident has completed the process, so we do not as yet have data to support the success of the program. For the 2009 program, two of the three sites did not have a viable applicant and the program went unfilled at those sites. However, the application pool for the 2010 private practice vision therapy SCO residency programs had increased to an average of five applicants per site. Each of the five programs reportedly was working with an excellent resident, with several of the residents having been ranked at the top of their respective graduating classes. Our projection is that as the five current sites produce highly trained and successful residents, the applicant pool will continue to expand, thereby warranting additional sites.

It should be clear that the program is not in direct competition with institutional residencies in vision therapy and rehabilitation. Rather, it poses a viable and complementary alternative to institutional residencies. Applicants who envision a career predominantly in clinical academia or research are better

served by applying to institutional residencies. Conversely, applicants leaning toward a career predominantly in private practice should be encouraged to apply to private practice residencies.

References

1. Maples WC. Editorial. The accessibility of behavioral optometry. *J Behav Optom.* 2007;18(2):30.
2. Garzia RP. The relationship between visual efficiency problems and learning. In MM Scheiman, MW Rouse, eds. *Optometric Management of Learning-Related Vision Problems.* 2nd ed. St. Louis: Mosby-Elsevier 2006;209.
3. Garzia P, Borsting EJ, Nicholson SB, Press LJ, Scheiman MM, Solan HA. *Optometric Clinical Practice Guideline: Care of the Patient with Learning Related Vision Problems.* St. Louis: American Optometric Association 2008 (Rev):7-8.
4. Ciuffreda KJ, Kapoor N, Han Y. Reading-related ocular motor deficits in traumatic brain injury. *Brain Injury Professional.* 2006;2(30):16-20.
5. Lee PP, Hoskins D, Parke DW. Access to care: Eye care provider workforce considerations in 2020. *Arch Ophthalmol.* 2007;125:406-410.
6. Soroka M, Krumholz D, Bennett A. The practice of optometry: National Board of Examiners in Optometry Survey of optometric patients. *Optometry.* 2006;77:427-437.
7. Convergence Insufficiency Treatment Trial Study Group. Randomized clinical trial of treatments for symptomatic convergence insufficiency in children. *Arch Ophthalmol.* 2008;126(10):1336-1349.
8. PEDIG Study Group. 2005 randomized trial of atropine regimens for treatment of moderate amblyopia in children aged 7 to 17 years. *Arch Ophthalmol.* 2005;123:437-447.
9. College of Optometrists in Vision Development. International Examination and Certification Board. Available at: <http://covd.org/AboutCOVID/IECB/tabid/278/>

Default.aspx. Accessed November 4, 2010.

10. Rouse MW, Appelbaum M. The future of vision therapy in optometric education. *J Behav Optom.* 1990;1(8):212-214.
11. Association of Schools and Colleges of Optometry. Optometric Residency Titles and Descriptions. Available at: <http://www.opted.org/i4a/pages/index.cfm?pageid=3570>. Accessed November 23, 2009.
12. Kraskin Invitational Skeffington Symposium on Vision, January 24-26, 2009, Washington, D.C. KISS 2009 Presentations. Available at: <http://skeffingtonsymposium.org/2009Presentations.aspx>. Accessed November 28, 2009.
13. Association of Schools and Colleges of Optometry. FAQs about Residencies. Available at: <http://www.opted.org/i4a/pages/index.cfm?pageid=3430>. Accessed November 23, 2009.
14. Southern College of Optometry. Residency Program Descriptions. Available at: <http://www.sco.edu/residency/Pages/descriptions.aspx>. Accessed November 23, 2009.