# Integrating Ophthalmological and Optometric Services in a VA Hospital Program

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**Synopsis**

*Basic eye care has been available at the Veterans Administration Medical Center (VAMC), Northport, NY, for the past 20 years. The demand for these services increased as the mission of this medical center was broadened to include major medical and surgery services. Increased migration of veterans to Long Island and their subsequent aging further increased the demand for eye-vision care.*

*Originally, primary eye-vision care was provided independently by optometry and ophthalmology services. There was unnecessary duplication of equipment and inappropriate utilization of providers. Consequently, the services provided were quite limited in scope and sophistication. Both patients and providers became disenchanted with this practice mode.*

*In December 1983, the administration of the Northport VAMC approved the establishment of a coordinated eye-vision care program that integrates ophthalmological and optometric services in a matrix structure. Since the program became operational in April 1984, patient satisfaction has increased, the working relationships between optometrists and ophthalmologists have improved, the ophthalmology residency program has been upgraded, and the combined staff productivity has increased.*

THE DELIVERY OF QUALITY EYE-VISION CARE, which ranges from basic primary care to secondary and tertiary levels of care, is a major emphasis of the Veterans Administration Medical Center (VAMC), Northport, NY. The eye-vision program is an integral part of the facility's comprehensive rehabilitation efforts, which not only provide the physical requirements of patients, but also their environmental, social, psychological, and cultural needs. This emphasis, coupled with an increased demand for eye-vision services by elderly veterans, prompted the VAMC administration to alter how vision care is delivered by taking a new approach that is more rational, efficient, and effective. In this paper we describe the traditional approach to eye-vision care that existed at Northport and is still the major mode of providing eye care elsewhere, the rationale for change at Northport, the restructured program, and the results of this reorganization.

## Traditional Delivery of Eye-Vision Services

Basic eye care, essentially eye health detection, refraction, and noncomplicated medical and surgical treatment, has been available to veterans at the Northport VAMC for the past 20 years. These services were initially only for psychiatric patients because the Northport institution was a psychiatric facility. In the early 1970s, the mission and identity of the medical center was changed when it became an active medical and surgical facility affiliated with the State University of New York (SUNY) at Stony Brook. Today about one-third of the hospital's 832 beds are devoted to psychiatric patients. Accompanying this change in focus was a

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marked increase in the demand for eye-vision care caused by a large increase in the number and age of veterans being serviced. As noted in the length of stay in hospitals in the Professional Activities Study (*1*), there is a direct relationship between the prevalence of eye-vision problems and age.

This increase in demand for eye-vision care becomes evident when one examines the growth of optometric and ophthalmological services at Northport VAMC. From 1965 through 1974, one optometrist working 8 hours per week and examining 15 patients per day was the sole provider of eye-vision services. No ophthalmological care was available at the center except for a staff psychiatrist with an ear, nose, and throat subspecialty. Patients needing more specialized services were referred to other facilities. From 1975 through 1978 optometric services were increased to 16 hours per week, and care was provided to 30 patients per week. Limited ophthalmological services and eye surgery were also performed by attending ophthalmologists. After 1978 the optometric and ophthalmological staff was augmented due to a dramatic growth in the population served by the medical center. Approximately 6.4 full-time employee-equivalent (FTEE [one employee working 40 hours a week]) optometrists, ophthalmologists, and nurses were involved in direct patient care, and their care still did not meet the increased demand.

At this time eye-vision services were provided along traditional lines. Responsibility for care was independently assigned to two services, optometry and ophthalmology, with overlapping responsibilities and duties. Each service was headed by a chief who had both administrative and professional authority and who operated independently. Therefore, each service competed for patients, equipment, and support personnel. Often this competition strained relations between these two services. Although trained to provide different levels of care, both optometrists and ophthalmologists often functioned almost interchangeably in the realm of primary care. Thus, professionals were inefficiently used; for example, a surgeon performing primary vision services. In addition, some of the equipment and supplies were duplicated in both services, resulting in inappropriate use of resources. This limited available resources and resulted in a dearth of state-of-the-art diagnostic and therapeutic equipment. Consequently, expansion of treatment options was restricted.

Both groups of professionals became disenchanted with this mode of practice because the level of care they provided was not commensurate with their training. As a result, staff turnover increased as productivity decreased in specialized surgical and medical areas. Patients became disenchanted with the care they were receiving in these specialty areas, and they complained to management. The ophthalmology residency program, which has 12 residents and a 1-year rotation and is affiliated with Nassau County Medical Center, East Meadow, NY, also felt the effects of this compromised delivery system. The residency program was in jeopardy of being canceled by one of the sponsoring organizations.

## Climate for Change

The situation became more serious as the increased demand by veterans for treatment of visual impairment was projected by the Veterans Administration's central office to continue through the rest of the century. The medical center's administration recognized these difficulties and mandated that a cooperative program be developed. This recommendation was in agreement with a 1978 report by the Comptroller General of the United States (*2*). The Comptroller General advised the Administrator of Veterans Affairs at the central office to direct the Chief Medical Director to (*a*) develop eye-vision care programs using both optometrists and ophthalmologists, (*b*) strengthen those programs considered to be inadequate, and (*c*) develop guidelines for optimal optometrist and ophthalmologist staffing levels and roles and responsibilities of optometrists, with emphasis on their interaction with ophthalmologists in Veterans Administration (VA) medical facilities. Alternative systems for eye-vision care employing this interactive approach were explored in the Comptroller General's report.

The personnel utilization model suggested by U.S. Senate Report No. 95-860 provided eye-vision services more cost-effectively than any other system (*3*). In that model, services should be provided by the health practitioner who by training and practice is best suited to deliver primary health services, and adequate referral patterns should be established with other specialists in the field for secondary and tertiary care. For example, primary vision care services would be delivered by an optometrist, and secondary and teritary vision care services would be provided by an ophthalmologist. Thus, each profession would perform services commensurate with the practitioners' training. By using optometry with other health disciplines, a multidisciplinary clinical facility can offer its patients optometry's training and skills as well as ready access to ophthalmological services and care by those trained in other medical specialities (*4*).

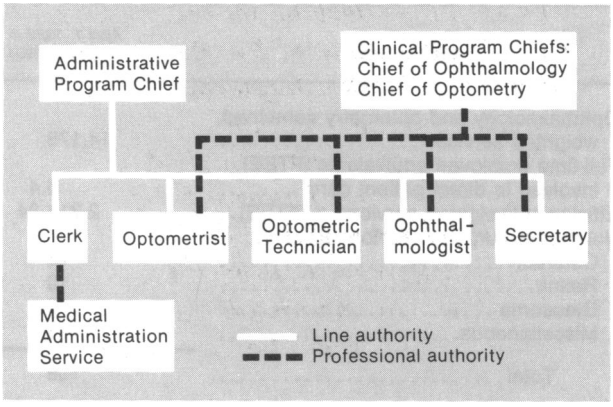
## The Eye-Vision Care Program

In December 1983, the administration of the Northport VAMC approved the establishment of a coordinated eye-vision care program. The program was administratively organized under a matrix structure because the conventional VA organization would not effectively foster a team approach to delivery of eye-vision care (*5*). Matrix organization, which develops a cooperative relationship between any vertical or horizontal hierarchies in a particular function, is essentially a variation of the team approach (*6*). The matrix management style is thought to integrate effectively overlapping interests and contradictory goals; enhance organization fluidity; discourage rigid, vested-interest and goal-seeking behavior related to territorial issues; increase the efficiency of resource use; and promote proactive behavior and thinking.

Under this structure, optometry and ophthalmology are brought together under the direction of a program chief who may be any qualified professional. The chief is administratively responsible for operation of the program. He or she has line authority over the professionals as well as the nonprofessionals in the program, while each service chief retains clinical authority over his or her professional staff. Thus, administrative and professional responsibilities are separated (see organization chart).

In the eye-vision program, optometrists and ophthalmologists use space and equipment efficiently. This enables the purchase of a maximum amount of equipment, including state-of-the-art technology previously beyond the means of each service independently. Integration of ophthalmological and optometric diagnosis and treatment modalities is a key to efficient and effective eye-vision care. This integration, effected by matrix organization, results in combined staff meetings, joint educational experiences, and cooperative efforts of optometry and ophthalmology residents. Implementation of this innovative program has had a positive impact on both the providers of care and their patients as described subsequently.

Organization of the eye-vision program, Veterans Administration, Northport, NY




## Results

The eye-vision program has been in effect since April 1, 1984, and substantial clinical and administrative benefits have resulted from this realignment, with the addition of only 0.5 FTEE clinical staff.

First, patient satisfaction has increased. When eye-vision care had been provided by two services working autonomously, two to three letters of complaint were received weekly by the Ambulatory Care Administrator. No patient complaints have been received since the new program has been in full operation.

Second, the working relationship between members of both professions has improved significantly. Optometry and ophthalmology residents now freely communicate and cooperate with each other on patient care. Optometrists and ophthalmologists share sophisticated equipment. Staffing has stabilized due to decreased staff turnover, which in turn has resulted in an enhanced team approach and improved morale.

Third, the ophthalmology residency program, once threatened by closure, is now commended in

Weighted services by ophthalmologists and optometrists before and after implementation of an integrated vision care program, Veterans Administration Medical Center, Northport, NY[1]

| Comparison units | April 1, 1983 to March 31, 1984 | April 1, 1984 to March 31, 1985 | Percent change |
|---|---|---|---|
| Ophthalmology and optometry combined, weighted services | 14,175 | 17,346 | +22.37 |
| Full-time employee equivalents (FTEE) involved in direct patient care | 6.4 | 6.9 | +7.81 |
| Efficiency (weighted services ÷ FTEE) | 2,214.84 | 2,513.84 | +13.50 |
| Number of surgeries performed: | | | |
| Cataract | 78 | 163 | +108.97 |
| Retina | 10 | 17 | +70.00 |
| Glaucoma | 2 | 5 | +150.00 |
| Miscellaneous | 18 | 23 | +27.78 |
| Total | 108 | 208 | +92.59 |

[1]The unit of a weighted service is a half-hour visit. Longer visits are counted multiple weighted services.

personal correspondence. This change resulted from both the addition of a 0.5 clinical FTEE ophthalmologist and an increased staff commitment that is necessary for a good educational program. Specifically, the clinical rotation at the Northport VAMC offers the ophthalmology residents from Nassau County Medical Center a large volume of ophthalmic pathology and surgery cases, with attending supervision and instruction in all phases of ophthalmology in a pleasant environment with updated facilities and equipment.

Finally, although the clinical staff now devotes an increased portion of its time to education, there has also been an upsurge in productivity (see table). State-of-the-art surgery is now performed, and there have been 92.5 percent more surgeries performed than before the new program. In the year since then there has been an increase of more than 3,171 weighted optometric and ophthalmological primary care services provided (a weighted service equals a half-hour visit), for a total of 17,346 weighted services—a 22.34 percent increase. Efficiency (weighted services ÷ FTEE) has increased by 13.5 percent.

## Conclusion

The integration of ophthalmological and optometric services in an eye-vision care program has resulted in patients receiving timely state-of-the-art care. The medical center now provides more sophisticated eye-vision care and is recognized as a quality program by the Council of Optometric Education of the American Optometric Association, the SUNY College of Optometry, and the Nassau County Medical Center. The provision of eye-vision services at the Northport VAMC is more effective and efficient than it was under the traditional delivery system.

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