I am privileged to have observed the evolution of the treatment of eye disease by the profession of optometry. Over the last 40 years optometry has become a major player in that arena. The profession now treats many conditions, depending on state law, with topical, oral, and injectable medications. By and large this is true for the overwhelming number of optometrists whose practices are now termed “full scope.” There are times, however, when the pathological condition is beyond the comfort level of the primary care optometrist. When this occurs, the generalist will enlist the assistance of a specialist. Of course, a network of referral/consultation has been in place with our medical colleagues in ophthalmology, neurology, pediatrics, family medicine, physiatry and others for years. However, an elaborate network of consultation and referral has been developed to assist the OD with these difficult pathology cases, within optometry.

I am surprised by how swiftly this optometry-optometry network has developed. It is unique in that the networking is specifically within the profession. Consultation and referral centers manned by optometrists are available for the primary care optometric practitioner. When it becomes clear that a presenting pathological condition is not responding to treatment, or the condition is something that the doctor does not feel comfortable treating, the referral center is called and a consultation is requested. The use of such services insures that the patient with an eye pathology is treated at an appropriate level and keeps the referring optometrist as an integral part of the treatment. At the same time, it helps ensure that the eye surgeon is working at his highest level of care, in the surgical suite. This model also ensures that the patient returns to the primary care optometrist for all future optometric care. This is a very efficient and cost sensitive way to deliver eye and vision care to the public. This system should be continued, encouraged and expanded.

This system is also applicable to behavioral optometry, most notably, vision therapy (VT). Unfortunately, at the moment it appears that the primary care optometrist does not offer VT, and many optometric students perceive VT as a specialty area within the profession. My firm contention is VT has a place in the primary care optometric office. The curricula in every school and college of optometry in the United States includes courses in the diagnosis and treatment of anomalies of binocular vision and impaired visual information processing. As such, VT is part and parcel of primary care optometry. Yet, if practicing optometrists were polled today, relatively few would report that they routinely provide in-office VT. This is because of the specialty status attributed to VT. Supporting this specialty model is the fact that for over 40 years the College of Optometrists in Vision Development (COVD) has been testing and certifying specialty status to those who have completed its fellowship process. Indeed, VT is both part of primary optometric care and a specialty area. Just as the primary care optometrist treats certain eye diseases, he/she should also treat vision conditions that require VT. And, just as the primary care optometrist will consult with specialty care when the condition is beyond his comfort level, as with pathology, so should the primary care optometrist consult with a specialist in VT when the condition is also beyond his or her comfort level.

The system that I have long advocated to my students is two tiered and mirrors the primary care, medical model. The primary care optometrist is responsible to identify and treat ALL eye and vision problems that present to that office. In the case where VT is indicated, treatment can entail all the armamentarium allowed by the particular state law. Lenses, prisms and other optical devices and yes, pharmaceuticals (e.g., atropine for amblyopia) are all tools for behavioral optometrists. Advice as to visual hygiene, the use of filters, occluders, magnifiers and lighting systems are also part of primary care. Optometry should also consider basic optometric VT as part of the primary care package. The basic diagnosis of symptoms and signs of ocular motor, binocular, accommodative and visual information processing deficits that are not alleviated by lenses and/or prisms should be treated with basic VT procedures. Furthermore, this should be accomplished in the primary care optometric office.

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to information in these areas as we feel adequate. With an introduction and some references to further data and publications, those who wish to can further explore binocular vision and vision therapy on their own campuses and with local OEP Associates,” stated Toon in accepting the appointment.

OEP, in conjunction with the College of Optometrists in Vision Development and the Rosemore Family Foundation, provides the Binocular Vision Kit (Kits) to all third-year members of the AOSA throughout the United States and Canada. Corporate support is received from the Bernell Corporation and Good-Lite. Approximately 1600 Kits are distributed annually. The Kits contain a CD with several noteworthy articles from JBO, Optometry and OVD on vision therapy and binocular vision, a Hendrickson Lifesaver Card, a Mystery Picture (Cow Card), a Brock String, a nearpoint card and nearpoint target. Feedback from student recipients directly and through AOSA has been very positive.

Dr. Toon will work with the OEP Board and AOSA leadership to further enhance the value of the Kit.

**ACBO NEWS**

**CHILDREN’S VISION DAY**

The Optometric Association’s Children’s Vision Day was held March 10, 2011 and aims to raise awareness of the importance of good vision in children, especially as it relates to successful learning and positive behavior in the classroom. Primary schools were invited to participate in the Day by ordering free Children’s Vision materials, running eye health and vision activities and asking an optometrist to visit their school to talk to students, parents or teachers and assist with activities.

**OEOPers IN THE NEWS**

The January 2011 issue of Bottom Line/Health published an article, “Could Your Attention Difficulties Actually Be from Eye Trouble?” based on an interview with Stanley A. Appelbaum, OD, FCVO, an optometrist in private practice in Bethesda and Annapolis, MD. Appelbaum contends that the diagnosis of ADHD is often incorrect in adults as well as children.

Kellye Knueppel, O.D., was featured in an article published at the community news site Brookfieldnow.com on November 3, 2010. In “Optometrist donates time, vision to Special Olympics” Dr. Knueppel’s work with disabled athletes is featured.

“In the world of optometry, Kellye Knueppel is a bit of a visionary. Knueppel, of Elm Grove, is the clinical director for Special Olympics Lions Clubs International Opening Eyes program for Wisconsin.

“Knueppel and her staff at the Vision Therapy Center, Brookfield, volunteer to provide Special Olympics athletes with complete vision assessments and exams at Special Olympics events. The team sets up mobile clinics and musters about 100 volunteers to assist with the project.

More than 3,100 pairs of glasses and sports goggles have been prescribed over the years, some made on location. All the lenses and frames are donated.

Because she has expertise in working with people who are living with developmental disabilities and delays, Knueppel was recruited to volunteer for Special Olympics. People with developmental issues tend to have more functional vision problems, she said, such as lazy eye, anisometropia (one eye that sees farther than the other) and crossed eyes.

The population also tends to require more high-prescription lenses. If a patient has difficulty adjusting to new glasses - as many people do with a set of new lenses - Knueppel gradually steps up the prescription to make the transition easier. Otherwise, she said, the glasses could simply end up in a drawer.

“Special Olympics athletes and others with disabilities are often not given complete eye exams during regular checkups,” Knueppel said. Some providers assume a patient with a developmental disability does not hold a job. But many adults with disabilities do work, she pointed out, and it’s important to ask them what type of work they are doing in order to provide the right type of eye care. For individuals with cognitive disabilities, getting glasses can be a life-altering experience. When they are able to see clearly, they are better able to pick up on social cues and interact.

Knueppel recently received the Award of Excellence from Special Olympics, given to individuals who provide extraordinary support and creativity in providing services to Special Olympics athletes.

**EDITORIAL continued**

accomplished in the primary care optometric office.

I would like to suggest the following protocol based on the primary care medical model of optometry. When a patient is diagnosed with a problem that requires treatment beyond lenses and prisms, a course of VT is offered by the primary care optometrist. The conversation with the patient/parent might go something like this:

Mr./Mrs. Jones, I have made a diagnosis of (fill in the blank-ocular motor, binocular, accommodative and/or perceptual dysfunction). This condition will require treatment more than lenses to solve this problem. It will require a specialized type of therapy that encourages the nervous system to learn to adequately control (fill in the blank-eye movements, eye teaming, focusing, information processing). My recommendation is that we institute such a program with you/your child. I will design the procedures and my staff will administer the therapy.

Such a scenario is an example of verbage that might be used to talk to patients and initiate treatment of the condition at the primary care level. Of course the caveat is that the optometrist must believe that treatment is well within his or her competency. And, as is the case with ocular pathology, when this is not so, or the patient is not responding appropriately, a referral must be made. I suspect that if the primary care optometrist follows this plan, he would soon find an increased confidence in his ability to offer effective VT. The profession can feel comfortable that there are specialists to consult when the case is outside the doctors’ comfort level. This two tier delivered system should work as well for VT as it does for ocular pathology.

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