OEP
CLINICAL CURRICULUM NEWS

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New Contact Information

Theresa has a new email address: TheresaKrejciOEP@verizon.net Please use this new address anytime you want to contact her or have any questions about the Clinical Curriculum, the Newsletter or for any other related business.

Opportunity Available

Bob Christensen in Mill Valley California is in need of an associate as well as a vision therapist. If anyone is interested, or knows of someone who might be available to help Bob, please call him directly, 415 381 3355.

Course Schedule

Due to numerous requests for special courses, the Sports Vision Course and The Optometric Treatment of Autism have been added to the 2005 schedule. The Sports Vision Course will be held April 9-10 and the Autism course will be held May 21-22. Both courses will be held in Baltimore. Please call Theresa or Karen 800 447 0370 to register. Remember, space is limited.

For the most current course schedule please visit the web site www.oep.org or www.babousa.org.

Equipment Available

After considerable discussion about the lack of availability of the Translid Binocular Interactor (TBI), OEP contacted a supplier who has developed a compact unit that is now available. The benefits of this compact unit are: light weight, portable, and very bright. The TBI runs off a 9 volt battery which is easy to change. The alternation rate is 11 Hz.

TBIs have been in use for approximately 30 years, and are known to be a great benefit as part of a complete and comprehensive treatment for suppression. The TBI operates at approximately 11 cycles per second, the alpha wave frequency of the brain. The TBI is simply placed against the patients closed eyelids and the red button depressed. The flashing lights cannot be suppressed.

Units are currently available. The cost of this compact unit with miniature electronics is $150. Contact OEP 1 800 424 8070 to order.

An Accommotrac is available for $3,500 from Tom Poswilko. If you are interested please contact him directly, at nwvisiondevctr@worldnet.att.net, or via phone at 815 398 9393

Questions and Answers

By: Paul A. Harris, O.D.

This line of questions came from a group of Europeans in the Clinical Curriculum course in Denmark.

Q. There are several things that I need to understand better concerning LRVP. I see many children with Learning Problems and almost in all cases I see something visual involved.

A. Welcome to the club. Remember how pervasive vision is in the makeup of who and what we are as humans. How much of the brain is involved? Remember the line of Gesell, "To understand the child one must understand the nature of the child's vision. To understand the child's vision, one must understand the child." Or the line, "Vision development is child development viewed optometrically." So what is happening is that you are now seeing this. You are right. It is nearly impossible for me to see a human being struggling with something and NOT have an unmet need that can be served by helping them improve their vision! The key is that we don't always have the whole answer. In other cases, some other professionals will need to be involved. In most cases, and this is my bias, we need to see what we can do first, because what we do is generally fast and so pervasive, before we bring in others.

Q. I need to improve my understanding into a child's perceptual assessments because I see many patterns that I don't understand. For example: How is it possible for a kid to have better scores in Visual-motor subtests of DTVP-2 than in Visual-perception subtests?

A. I think different people have different profiles of skills or abilities and that it is not productive to always think of things in hierarchical ways. You may remember discussing Howard Gardner's theory of multiple intelligences where he talks about us having a minimum of seven areas of independent intellects. One of these areas is in motor development. Some can have pushed their development in the area of eye-hand coordination, body awareness and movement well beyond their abilities in the more cerebral aspects of using the visual process. In others it may be the exact opposite, although we do expect things to happen first in three-dimensional space before moving into flat land. So the data is the data. Relative strengths and weaknesses are revealed and it is up to us to understand how the person is doing what they are doing and help them do those things that they want or need to do more effectively and more efficiently. This is a long way of saying that the data is what it is and try seeing where it leads you. I don't see this as always being one way or the other, but look for the profiles I get for a particular person. This gives me insight into how they are using vision to derive meaning and direct action.

Q. Is Accommodative Insufficiency (AI) a common finding among The Learning Disabilities (LD) population?

A. I don't really think of these kids with that label. But if I were to bend a bit and ask myself, "Do I see a number of children with an inability to sustain deriving meaning and directing action at a near (within arms reach) distance for long periods of time?" I would of course have to say, YES! My thoughts though are more along the lines of an inability to sustain the "selection of a point in space" from which they would derive meaning and direct action and I would not be thinking of a diagnostic category that breaks out just accommodation.

Q. And if "yes" what does this means? I have seen reduced amplitude of accommodation (MONO & BINO) in many cases with Learning Problems but with no symptoms.

A. I doubt with NO symptoms. The learning problem itself is a symptom. Again, be careful of an absolute. More likely there are symptoms that either you had not linked to a visual attention problem, or you and the patient hadn't explored deeply enough. There may be other areas of difficulty that also relate, but they didn't bring them up because they didn't see the possible relationship to vision or you did not ask.

Q. Is the most common sign in those cases avoidance of close work?

A. In the VT/Learning Related Visual Problems Course we generally bring this up. It is a Kraskin thing where he said that the number one adaptation to sustained near visual stress is avoidance and he called these cases, "reduced visual efficiency" cases. These can occur secondary to any visual problem not just one traditionally labeled as accommodative in nature. It all depends on how you look at learning. Many of the hard working and non-avoiding children are doing a terrible job of learning.

Q. But is AI a cause or a result?

A. The way I look at it, it can be both and they cycle back on each other. I don't see such a simple cause and effect chain, but rather complex interactions where there can be cycles that amplify small mismatches or small difficulties into life altering problems.

Q. Is it the accommodative training or the perceptual training that will make the Identification mechanism work as expected?

A. Again, YES! What I mean is that I would come back and ask you to back away a bit. Please recall the dialogue early in the VT/Visual Dysfunctions about the Kraskin 10 principles of VT. I see ALL activities/procedures as VISION activities and I don't break them into this being for accommodation and this for perception. ALL activities involve both all the time! So I'm not sure where the question is coming from. Stated another way: Many things can be learned by using a lens. Let's not limit our thinking to lenses working accommodation and prisms working vergences. We are in the field of VISION.

Q. I have seen a kid with AI but difficulty clearing plus in BAR & MAR (?) After 5 sessions of VT, the opposite pattern came on!!! Difficulty with minus!!! Is this the result of the initial effort?

A. I would like to know your thinking or interpretation. What we are looking at are ranges. Over time ranges can shift and become asymmetric. Ranges can collapse. Many things can happen to them. In VT we work to increase the overall range, to help the person move through their range more quickly with ease, to be able to, if they require, stay at one point in the range for a sustained period of time, and to do so in a fine manner with easy subconscious control. What you may be seeing is that while you put emphasis on one side of the range, it shifted for a period of time and appeared as a loss of the initial side. The range, through stimulation and use shifted. This goes back to the emphasis on any "rock" procedure. The benefit is not in the absolute power of the lens, but the opportunity it provides the patient to experience the rock and explore.

Consultation Corner

By: Robert Hohendorf, O.D.

Patient: AH **DOB:** 2/14/74 Female (age 7 yrs. 11 mos.)
Occupation**:** Child, 2nd[d] grade student

Chief Complaint:
1) Headache started 3 months ago (2 months after the start of the school year)
2) Blurry board when seated in back
3) A bit clumsy

Case history:
1) Eyes occasionally itch
2) Possibly allergic to aspirin
3) Family/Health, Maternal per natal thyroid removal
4) Good general health, full term, 9 lbs 2 oz., walked 10-11 months, history of good crawling pattern
5) Negative for Medications

CURRENT EXAM

Chairside Tests and History:
1) Dislikes math, likes Art ("socializing" and teacher)
Last year written work difficult (allowed to verbalize)
Loves to read, in top reading group, Cut & color skills good
Free time: Dancing to improve coordination
2) Laterally on self great, crossed (with thought) on others (directionally?)
3) Right handed, right footed, right eyed

King Devick	1	0 errors	24"	Head movement
	2	2 errors	30"	Finger Used
	3	4 errors	48"	Reverses 6's + 9's
		6 errors	98"	Speed age 7+, Accuracy age 7+8

Unaided Visual acuity: Far: OD 20/25, OS 20/25, OU: 20/20
Near: OD 20/20, OS 20/25, OU: 20/20
Cover test: Far: Lo ESO (<6)
Near: Lo EXO (<6)
Motilities: No head or body movement, no limitations Jerky
CNP: To nose
Stereopsis: 1 ½" lift of fly wing, 3/3med 9/9 small
Color: Misses 2 and two 1/2 half plates
Internal: 2/3 AV Hook .7 No MR noted
2/3 AV VD hook. .4 EXG MR
External: N.A.P.

#4 Retinoscopy:	OD: +0.25 45 +0.50
	OS: +0.50 +0.75
Mon refraction pre #7:	OD: -0.50 -0.37 x 25 20/25
	OS: –0.75 -0.37 x 25 20/25
#7 Subjective	OD: +0.75

OS: +0/50
#7A Largest OD: +0.50
OS: +0.25
OU: 20/20 -1
#8 dist phoria through Plano: 1 exo

Control Indicator : plano
#9/10 Far Equilibrium BO: x/moves left/4/**S** I L O
#11 BI: x/16/4
#13B Near Phoria 6 eso (2/1 gradient)

NEAR CONTROL: +1.00
#14A Unfused Cross Cylinder: OD: +1.50 **G**
OS: +1.50 **G**
#14B Fused Cross Cylinder: OU: +0.50 **G**
#15B Phoria with 14B: 7 exo
#16 Near Equilibrium: BO: 24/35/11
#17 BI: x/20/11
#20 PRA: +2.25 **G**
#21 NRA: -4.00 **G**
#12 Vertical Phoria 0rtho Supra Duction: 3/1, Sursum Duction– 2/1

I recommended +0.50 D Spheres for work within arms length.
My prognosis was for reduced frontal headaches associated with use of the eyes and improved distance clarity of sight without glasses.

AH was a young second grader. Today she is an elementary school teacher. Her visual path has been a winding one with several lessons provided for my development as well. I recommended I see AH back for a summer progress evaluation.

This appears pretty straight forward: Accommodative infacility or spasms causing headaches. This was prior to my BABO course work so stress point, RGR, and Worth 4 dot were not done. I used the tools I had gleaned from my optometric education and OEP post-graduate seminars. I also gave only one option for treatment at this time. Other than to do nothing, I used our best tool, a lens. I gave it in single vision form for full time wear.

I felt that accommodation relaxation and magnification would help AH organize her vision to see clearer and learn to move her eyes better. I think magnification helps minor oculomotor problems.

What would you recommend? Don't forget use 3 alternatives of care

Forward your email comments to: TheresaKrejciOEP@verizon.net, or fax to 410 252 1719.

IOP May Not Be The Key

Recent evidence culled from the original longitudinal myopia research study done by Ludlum et.al. as reported by Gordon Harris, O.D., one of the original members of the research team, showed that IOP was not significantly different between the two groups. Dr. Harris went back to the original data and instead of dealing with all 500 subjects carefully chose 30 sets of age-matched pairs. One set was stable

over a 3.5-year period with refraction changing only +0.09 D, meaning slightly more hyperopic, while the progressive set changed -1.53 D. The average age of the groups was 8.99 years for the non-progressive and the 9.45 years for the progressive group. Most of the changes were in the axial length but axial length change did not account for the whole difference.

In this subgroup the intraocular pressures shifted in both groups downward over the period of time of the study. In the non-progressive group their IOPs dropped 4.86 mm Hg and the progressive's dropped 4.78 mm Hg. Many other studies still do show IOP involvement and time locked changes in IOP but most of these seem to be looking at short-term IOP changes secondary to near-centered visual stress. In addition, IOP changes seem to be secondary to other changes that occur as part of the retinal defocus – neuromodulator models. So IOP does change and those changes may still be a factor in the differences between progressives and non-progressives. However, over a long time scale it appears that IOP in children begins high and drops over time and that there is no absolute difference in average amounts between those who will progress and those who will not.

Look for this extensive new information in the OEP Clinical Curriculum Continuing Seminar or plan to come back and audit the Art and Science course when convenient. The Continuing Seminar is a 2-day seminar for those attendees who have taken the full OEP Clinical Curriculum and who desire on-going stimulation of what's new. Contact Theresa for information about when this will be offered, TheresaKrejciOEP@verizon.net.

VT Scholarship Program

By: Rob Lewis, O.D.

A scholarship program is one way we can sometimes remove a potential barrier between a patient who can benefit from vision therapy and that patient's participation in the therapy program. In our office, we provide a number of either partial or full VT scholarships for those in need. Ten percent of the therapy done in our office is provided on a scholarship basis. We use the scholarship approach rather than a fee reduction or a sliding scale because it helps communicate the value of the therapy experience.

From the beginning of my experience as an optometrist, vision therapy has been an integral part of my understanding of vision care. It is enough to say that being a vision therapy patient changed my life. While I was a therapy patient, I became aware of a young man named Patrick who had a large angle esotropia. His family wanted very much to help him, but had few financial resources. The optometrist chose to give Patrick the therapy he needed. His act of compassion further set the stage for the way in which my practice life has gone.

One of our three primary goals is to make a positive contribution to the larger community outside our office. Through behavioral optometry, we have the opportunity to be a catalyst to change individual lives, and through those individuals, the community in which we live.

Vision therapy can have enormous positive effects on how people live their lives, but not everyone has the finances necessary to be able to afford therapy on their own. It seems my associates and I have always had patients who are paying reduced fees. In some cases, the fees were reduced to zero. If we thought there was a need, we tried to meet it. At first, we had no plan or structure in place to guide us except compassion. Sometimes more than half our patients were on some type of special arrangement. Not only was this type of inconsistency a bookkeeping nightmare, but the quality of our therapy suffered, and the practice suffered financially.

The most significant root problem in situations such as these is often a lack of "valuing" on the part of both the patient and the doctor. Too many times the value of vision therapy is mistakenly confused with the amount of the fee received for providing the therapy; a little like equating the tuition one pays with the value of an education. This mistake affects different people in differing degrees, but the general tendency is to participate at a lower level because the activity is experienced as "free". When this happens the results of the therapy are marginal and the office providing the therapy has not done anyone a favor. The first part of the solution is to realize within ourselves that the service we provide is of enormous value, and there is a significant cost to providing these services.

We explain to those patients who are in need of financial assistance that we can sometimes cover a portion of the costs of therapy through a scholarship program. The program is never referred to as free or a discount. We want each person to understand the value of the services in which they participate, and their personal responsibility for their own ultimate success.

The cost and the value of vision therapy are not entirely or even mostly monetary. I believe the primary cost of excellent therapy is the high level of personal commitment required of doctor, therapist, and the patient. We expect every patient to spend thirty to fifty minutes several days per week in addition to the time spent in the office. We know that this level of commitment and involvement will lead to expanded vision in every sense of the word. Every time we successfully complete a vision therapy program, a life changes for the better. This is an enormous return on investment before any fee is paid.

We dedicate ten percent of our therapy slots to scholarships. For instance, if we have 84 patients enrolled in our therapy program; there are 8.4 patients worth of scholarship available. These will usually be split between several patients who are each receiving a partial scholarship based on their need. In the example above, we might have one person who is receiving a 90% scholarship and paying $10.00 per visit in addition to a number of other persons who are receiving smaller amounts of assistance. These add up to a total scholarship of about $900.00 per week out of a monthly therapy income of just over $30,000.

We know the approximate length of each patient's program when they begin their vision therapy due to our use of curriculum based therapy. This makes it somewhat easier for us to administer a scholarship program than it might be in some other offices. This lets us plan for our expected census at any given time and makes it easier to allocate scholarships. Of course, once we begin a program with a scholarship in place, we will honor that commitment until the curriculum is complete or the patient leaves therapy for another reason.

There is usually a waiting list for therapy scholarships. Due to the relationship that often develops between therapy families and our therapists, and due to the limited number of scholarships available, patients and their families are motivated to provide the most they can from their own resources so that therapy can begin sooner. As mentioned above, the purpose of a scholarship is to remove a potential barrier between a patient's need for therapy and the successful completion of their therapy program. It seems that by keeping our scholarship program as full as possible, other potential patients are encouraged and make greater efforts to take part in therapy without assistance. We probably are seeing more patients, both full pay and scholarship, than we would be if the program was not in place.

Some helpful hints based on our experience over the years include:

Provide therapy as well as other eye care as a benefit of employment in the office. If we truly believe that a patient who has benefited from behavioral vision care is more able to realize their own potential as a human person, we would be foolish not to encourage our employees and their families to take full advantage of this opportunity. An employee whose family has benefited from the full scope of

behavioral vision care is our best and most enthusiastic representative. An employee who has the in depth knowledge acquired through participation in therapy is not only a more educated employee, but is a more able member of our staff. This type of service is provided as a benefit of employment and is not considered a part of the scholarship program.

It is very important to keep in mind that this is not a fee reduction program. This is not cut rate, nor is there any reduction in the length or intensity of the therapy program. In many cases, our therapists do not know who is receiving assistance and who is not. The scholarship program is a choice to actively participate in another's welfare by bearing some of the cost yourself.

In some cases we trade services or barter for materials and services in our offices. It is particularly important in these cases to make sure both parties to the transaction clearly understand the value of services, materials, etc., from the beginning. Keep the value picture clear. There is a much greater hazard of bookkeeping errors and misunderstandings in these situations than in more usual transactions. We do not consider these as a part of the scholarship program unless there is a trade combined with a partial scholarship. In the case of a trade and scholarship, we count the value of the trade as if we were paid cash. Any remaining balance is considered as a partial scholarship. Remember--The exchange value of goods and services is supposed to be reported as income to the IRS. Please discuss this type of arrangement with your tax preparer!

In many cases, to "accept insurance" results in a patient who undervalues their therapy program with the result that participation in homework and attendance may suffer. It is best if some amount can be collected or if the patient pays up front and is reimbursed for the program. This is true even when the patient is receiving a partial scholarship and their actual financial contribution is small. Those who "pay the cost" seem to get better results.

For those patients who have insurance, they must understand in advance that the scholarship does not apply to any part of their fee reimbursed by insurance. We have had the rare circumstance where a patient is unexpectedly reimbursed by their insurance and were unhappy that this amount was deducted from their scholarship amount. Patients must understand that this is a benefit provided on a need basis only and to abuse the privilege of their scholarship deprives others of a similar opportunity.

Expect every patient, scholarship or not, to keep a consistent therapy schedule. This is true of both attendance in the office and the completion of homework. Without commitment on the part of both the patient and therapist, it is almost impossible to have a fully successful outcome. The price of an indifferent approach to therapy is often a patient who is never able to reach their full potential and who will communicate the outcome of their therapy to others in any number of ways. The ultimate result is that not only does the original patient suffer, but others are discouraged from experiencing the benefits of behavioral vision care. If a patient has difficulty, it is far better to stop while the door remains open so that it is possible to return and experience the full benefits of therapy in the future.

Let your major referral sources know that you have chosen to make a number of scholarships available. Make this low key, but make sure they know that you have chosen to contribute to the welfare of their patients in this way. Not only will your colleagues know you are serious about helping others, but when a patient says that therapy is too expensive, your referral sources will know you've done your part to make the benefits of your care available.

**This information was taken from: Tips for Growing Your Practice, published by OEP 2000. For additional information, please contact OEP 949 250 8070.*