GUEST EDITORIAL

BABY STEPS

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On April 4, 2001, I had the opportunity to participate in a conference sponsored by the Harvard Graduate School of Education. The conference was conceived and implemented by Drs. Antonia (Toni) and Gary Orfield. Dr. Gary Orfield is a Professor at Harvard's Graduate School of Education and Dr. Antonia Orfield is an optometrist affiliated with both the Harvard University Health Service and the New England College of Optometry. Toni has been providing vision services to inner-city children at Boston's Mather School for six years. The Doctors Orfield have been viewing the issue of poverty from different sides of the fence; Toni from the perspective of a behavioral optometrist with first hand experience of poverty's impact on vision and learning, and Gary from the perspective of educational policy. For one day, the fence was removed, and optometrists and educators shared a wide view of the landscape. "It is time we had a discussion between people concerned about vision and people concerned about education," stated Dr. Gary Orfield.

Although sponsored by the Harvard Graduate School of Education, the spotlight was on optometry. Eleven optometrists presented papers. Drs. Bruce Moore and Patricia Kowalski defined vision and the limitations of school based vision screenings. Drs. Toni Orfield, Robert Duckman, W.C. Maples and I, provided a healthy dose of reality with overviews of projects that delineate the extent of vision problems in poor populations and their correlations with academic non-performance. Dr. Joel Zaba widened the perspective by describing the relationship between undetected vision problems and illiteracy and delinquency. Dr. Kenneth Ciuffreda discussed the legitimacy of vision therapy as an efficacious treatment modality from the perspective of a objective, quantitatively-oriented vision scientist.

For me, the most exciting part of the meeting was the presentations by optometrists on the front line. Drs. Joseph Sullivan, Paul Harris and Stephanie Johnson Brown are actively involved in school-based programs that are providing vision therapy services to students with diagnosed visual deficits. Although the models of patient care delivery differ, they are all based on the logical sequence of identifying visual deficits, providing treatment, and measuring outcomes (both visual and academic). All have required the leadership of a "principal investigator" and the commitment of many participating optometrists. All faced difficult questions in designing their projects in order to balance patient care and the validity of the research component. Each one of these projects brought into view some of the hills and valleys in the vast landscape of "vision and learning." This issue of the *JBO* contains three papers that were presented at the conference.

The audience did not require a hard sell. Many of the educators and school administrators in attendance spoke of their frustrations associated with their attempts to obtain vision services for their students. More often than not, the discussion boiled down to the bottom line: how much will it cost and what is the expected return on the investment? It struck me that this perspective on vision and learning is very different from that of the vast majority of behavioral optometrists in private practice. The private practitioner sees one child with a singular clinical presentation which requires an individualized management plan. The ascent of managed care has fortified this philosophy by deeming large groups of patients as "ineligible" to receive vision therapy services. Consequently, optometrists are increasingly forced to offer a fee for service plan on a case-by-case basis in order to provide the necessary services. But if a goal of the profession is to place the important relationship between vision and learning onto educational policymakers' radar screens, there must be a shift toward a public health perspective. Optometry's war against academic failure must adopt a population-based research strategy and a legislative agenda.

As explained by Dr. Sullivan, the Kansas Project is a perfect example of developing a population-based research project as the result of carefully planned years of legislative lobbying based on an increasing body of evidence of the relationship between vision and learning. Eight years ago, the Kansas Optometric Association (KOA) created the See to Learn program, which offered free vision screening to preschoolers in

optometric offices across the state. Today, the Kansas legislature has appropriated $250,000 to the KOA to provide vision therapy services to students with accommodative and vergence

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dysfunctions. It is important to realize that this grant did not result from the work of one individual with expertise in the design of clinical trials. Rather, it grew from the collaborative efforts of dedicated practitioners across the state, who took small steps, baby steps, forward and built on each success. Now we are witnessing the snowball. Kentucky became the first state to require that children undergo a comprehensive vision examination before entering school, and preliminary findings indicate greater than expected numbers of children with significant vision problems. Presently, Missouri, Massachusetts and Connecticut are considering similar legislation.[1] These and other States can receive guidance and support from the Children's Vision Initiative which has representatives from the American Optometric Association, Operation Bright Start (American Foundation for Vision Awareness), the American Academy of Optometry, the College of Optometrists in Vision Development, the Optometric Extension Program Foundation, and the Kansas Eye Care Council.[2] These legislative efforts will create opportunities to conduct population-based research studies that ultimately will address the bottom line: how much will it cost and what is the expected return on the investment?

During the conference, I had a conversation with Drs. David Heath, Vice President of Academic Affairs at the New England College of Optometry, and W.C. Maples about the need for high quality controlled studies of the efficacy of vision therapy for the learning disabled. It was pointed out by Dr. Heath that most major grants are not awarded the first time through the process. More often, they require pilot projects, refinement of research protocol and the collective insights of clinicians, statisticians, and vision scientists. In other words, they require baby steps. It is not appropriate to wait for that one research project that will verify our credibility to third party payers, while we change one life at a time. We can no longer afford to view the landscape from one side of the fence. Every behavioral optometrist must begin to take those baby steps toward adopting a public health perspective. Everyone can contribute to the effort.

My contribution will come as Associate Editor of this journal. I will seek out those of you who have been involved in school-based programs and encourage you to publish the results of your projects. There is something to be learned from each of them, be it better methods to define visual deficits, the operational difficulties associated with providing vision therapy in a school setting, or expected outcomes for a defined population. Publishing your work and disseminating your knowledge and insights allows the next behavioral optometrist to take another step forward. Eventually, with enough baby steps, high quality meaningful research will evolve. There, I have made public my commitment to behavioral optometry's public health agenda. Now, it's your turn.

References

1. Momentum is building in states for mandatory pre-school eye exams. Am Optom Assn News; March 5, 2001:1, 4.
2. Children's Vision Coalition to stress that screenings are not exams. Am Optom Assn News; March 5, 2001:1, 4.

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