OCOS General Meeting & Membership Drive

VSP In House to Discuss What’s New

1 Hour CE
“Scleral Lenses”
Lance McNaughton OD, PhD

Monday, October 14
6:30 - 9:30 pm

FREE for OCOS ODs who bring a Non-Member OD
$45 COA members • $65 non-COA / At the Door

Charlie Palmer @ Bloomingdale’s, Costa Mesa
RSVP at www.ocos.org by 10/13/13
Dear Colleagues,

As I write this message, a health care reform is just right around the corner. Covered California (http://www.coveredca.com/), our state’s health insurance marketplace, enrollment starts October 1, 2013. I’ve been following the weekly CA Affairs update from COA to see how this impacts us as optometrists. Here is a brief overview for you from the COA:

**Pediatric vision benefits** - Most health plans in the exchange will contract with a vision plan to provide the pediatric vision essential benefit required under the law. The benefit includes an eye exam and glasses for children up to 19 years of age. Plans will be required to offer at least one no-cost option for eyeglasses in order to comply with the pediatric vision materials benefit.

**Adult vision** - While California passed a law that required plans to include adult vision coverage, the federal guidance has been interpreted to prohibit adult vision coverage from being included as part of the mandate. COA will continue to push for an adult vision coverage mandate. Supplemental adult vision coverage will likely be offered through Covered California eventually. Covered California is having problems figuring out how to provide that coverage within federal guidelines. COA continues to advocate that Covered California should ensure that this coverage is made available in a timely way.

**Health plans** - Covered California will offer many of the same health plans available on the private market today.

**Individual consumers** will have a choice of up to 12 health insurance companies through Covered California, depending on location. Anthem Blue Cross, Blue Shield and Kaiser are available in all counties.

**Businesses with 50 or fewer full-time equivalent employees (FTEs)** will be able to choose from six carriers through the Small Business Health Options Program (SHOP). The plans, similar to those usually only available to larger employers, will be available from Blue Shield of California, Chinese Community Health Plan, Health Net, Kaiser Permanente, Sharp Health Plan and Western Health Advantage. [Tax credits](#) are available to eligible employers for 25 or fewer FTEs.

October also marks our membership drive. We are always looking for new ODs to join our society and represent optometry to our legislators. On October 14th, we will having our membership CE with Dr. Lance McNaughton from Western University talking about scleral lenses. Bring a non COA member, enjoy some great food, and get your CE for FREE! VSP will also be at the dinner to discuss their new lenses and provide updates. I look forward to seeing you there!

Sincerely,

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harvardeye.com
Fall Games will be December 14-15 in Fountain Valley

We will begin recruiting volunteers soon for the Opening Eyes vision screenings. If you are interested in helping, please contact Dr. Kristine Huang at khuang@ketchum.edu.

Oath: “Let me win. But if I cannot win, let me be brave in the attempt.”

Mission: “To provide year round sports training and athletic competition in a variety of Olympic-type sports for all children and adults with intellectual disability, giving them continuing opportunities to develop physical fitness, demonstrate courage, experience joy and participate in a sharing of gifts, skills and friendship with their families, other Special Olympics athletes and the community.”

- The concept was born in the early 1960s when Eunice Kennedy Shriver (John F. Kennedy’s sister) started a day camp for people with mental retardation. She saw that individuals with intellectual disabilities were far more capable in sports and physical activities than many experts thought. Eunice believed lessons learned through sports would translate into competence, success in school, in the workplace and in the community.

- For children (minimum age 8) and adults with Intellectual Disabilities. Physical disability is not a criteria, but about 1% of athletes also have physical disabilities. There is also a new Young Athletes program— a unique sport and play program for children between ages 2 ½ and 8. More than 50,000 children are participating.

- Today, there are nearly 3.7 million athletes in 170 countries, and 32 sports. And, over 11,600 athletes from 11 counties in Southern California participating in 12 sports.

- Athletes train and compete year round in Local Area Programs. Through Area competitions, athletes compete and qualify to participate in Chapter-level Games (e.g., Summer Games).

- 3 levels of sports competitions: Area competitions, Regional competitions, and Championships.

- Special Olympics Southern California has a two-season sports calendar – Summer and Fall. Summer sports include Aquatics, Athletics (Track & Field), Basketball, Bocce, Golf, and Gymnastics. Fall sports are Bowling, Floor Hockey, Soccer, Softball, Tennis, and Volleyball.

- Special Olympics World Summer Games will be hosted in in Los Angeles. More than 7,000 athletes from 170 countries are expected to compete in 21 sporting events. It will involve 40,000 volunteers and 500,000 spectators.
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“It has been my pleasure to work in cooperation with family eye doctors for over 15 years” - Tom Tooma, MD, Founder
Founded in 1984, Combat Blindness International (CBI) has been working in the developing world for almost 30 years. Our primary mission is supporting cost-effective cataract surgical intervention to those who cannot afford it, where a blind man, woman or child will see once again for just $20. We can do this at such a low cost because of strategic partnerships with indigenous medical facilities and professionals, and direct access to low-cost, yet high-quality intra-ocular lenses. All medical procedures and related labor is provided free by volunteers.

Since its inception, 650,000 people received comprehensive and critical eye exams, and more than 170,000 men, women, and young children have received sight through free cataract surgery; people in India, Africa, East Asia, the Middle East, and North and South America. Through life-saving interventions, if we do nothing, there will be 74 million more people blind by 2020. 90% of these people live in remote areas without access to proper medical care. 80% have treatable or preventable blindness.

In 1987, we recognized the need to prevent blindness in young children living in developing countries who were suffering from Vitamin A deficiency. We offered free screenings and supplied nutritional supplements to children via rural eye camps, and helped families integrate green, leafy vegetables that contribute to good eye health into their diets. Vitamin A deficiency has been the leading cause of preventable blindness in children under the age of 5. According to the World Health Organization, an estimated 250 million preschool-age children have been found Vitamin A deficient, and between 250,000-500,000 of these children go blind each year. Half of these children die a short 12 months later. All of this is preventable.

In 1984 CBI originated in Madison, Wisconsin, and in 2010 organized and began operations on the West Coast, in Tustin, California. In recognition of the ever-increasing global need for eye-care, CBI California Chapter has made it our goal to create a network of support by partnering with local professionals, donors, and volunteers, to provide resources for those in need globally. Combat Blindness California Chapter is actively sponsoring events in Southern California. We are currently in need of people to donate their time, finances, and supplies. Please join us in our mission to end preventable blindness worldwide. You can donate at our website www.combatblindness.org, or get in contact with our California office at cbi.california@gmail.com or (714) 669-1710. Thank you.
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Medical Breakthrough: DSAEK

More Advanced Technique for Patients with Fuchs Dystrophy — Ultra-Thin DSAEK offers better visual results for patients with corneal endothelial cell disease.

Fuchs Dystrophy is one of the most common corneal problems that leads to blurred vision. It occurs when the endothelial cells begin to lose function and deteriorate. The endothelial cells are critical to the maintenance of corneal transparency.

In the past, full thickness penetrating keratoplasty was the only solution. Although very successful, visual recovery was slow (one to two years). Rigid contact lenses were often required for best visual outcome due to astigmatism induced by the graft.

A number of years ago a new, and less invasive technique for correcting Fuchs Dystrophy was introduced. This was called Descemet’s Stripping Automated Endothelial Keratoplasty, or DSAEK. This procedure involved replacing only the back portion of the cornea (containing the endothelial cells). This could be done via a small incision with minimal surprises. The small incision was safer, and visual recovery was faster, with most patients achieving the 20/40 vision required to pass a driver’s test in about six weeks.

"DSAEK revolutionized the treatment of Fuchs. It allowed the patient to undergo a much less cumbersome procedure compared to a penetrating keratoplasty (PKP) and have a very fast recovery time," says cornea specialist John Hovanesian, M.D., of Harvard Eye Associates.

Ultra-Thin DSAEK

Although DSAEK is remarkable, with most patients reaching BCVA of 20/40 or better, Dr. Hovanesian and the cornea department of Harvard Eye Associates was looking for a solution that could even further improve visual acuity, and they found it with Ultra-Thin DSAEK. With this improved method for performing DSAEK, known as double-pass, Ultra-Thin DSAEK or UT-DSAEK, Dr. Hovanesian uses a much thinner piece of donor tissue, allowing for better, faster visual recovery. Ultra-thin DSAEK has a thickness of 50 to 75 μm, rather than 100 to 200 μm with traditional DSAEK.

In a recent study, the percentage of patients achieving BCVA of 20/20 or better at 3, 6, 12, and 24 months was 12.3%, 26.3%, 39.5%, and 48.8%, which is a huge increase over traditional DSAEK” says Dr. Hovanesian.

If you would like more information on Ultra-Thin DSAEK, contact Maria Michel at Harvard Eye Associates, 949-900-5228 or mmichel@harvardeye.com
We are excited to announce that TLC Laser Eye Centers has launched a joint venture partnership with Harvard Eye Associates at our Laguna Hills location.

TLC brings your patients the very best in technology, surgical outcomes and a personal approach for both LASIK and refractive IOL’s. TLC was founded on the philosophy of co-managing patients with Optometry, working with some of the most experienced surgeons while maintaining our strong commitment to our affiliate optometrists.

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Refractive Surgery in the Military

"Don't One of You Fire Until You See the Whites of their Eyes" – Col. William Prescott at the Battle of Bunker Hill in 1775. The problem with this statement is that over 50% of our soldiers couldn't see the whites of anything because of uncorrected refractive error. Can you imagine the fear of being a soldier on the battlefield and not being able to see your enemy? Thankfully, for both the American and Canadian military, this problem does not exist today. We have eye doctors that willfully serve their country to best prepare their respective troops for the inevitable. Actually, corrected refractive error is a huge advantage that we have over many of our enemies in conflict areas today.

In the American military, we have the option of glasses, contact lenses and refractive surgery. In combat designated areas and in special situations, contact lenses are not permitted. This is because of a wide variety of reasons not limited to infection and the possibility of them falling out in combat situations. Also, in general, pilots cannot use them while flying. That leaves glasses and refractive surgery as the two main options for vision correction. Glasses, while very effective, can be a problem in combat environments for obvious reason. They can fall off, break, restrict peripheral vision, fog up to degrade vision and be a problem to use with other protective gear.

Refractive surgery is a wonderful option for the right service member. It can eliminate all of these issues with glasses and contact lenses, leaving the service member free to do her/his job without an optical device in their view. Refractive surgery has been an approved method of vision correction since the early to mid 2000's. The Navy was the first to approve refractive surgery in the US military.

The military has specific rules on refractive surgery and furthermore, each branch has their own rules on the parameters of allowable refractive surgery.

We are so proud that TLC has done thousands of refractive surgery procedures on service members and potential service members over the years but it is important to understand that TLC is a civilian organization and not a military organization. TLC has no relationship with the military and their refractive surgery policies but often military service members or people that wish to join the military present to our clinics and strongly desire refractive surgery. It is the firm policy of TLC for the referring and co-managing optometrist, clinical director and surgeon to instruct the military patient to discuss their desire to have refractive surgery with their appropriate military people. If a procedure is performed on a patient that is not allowable according to the military rules and regulations that service member's job and career may be in jeopardy. Also, if a service member wishes to be part of a specific unit or group later in their career, certain procedures may exclude that service member from potential candidacy. For example, Custom Bladeless LASIK may be permitted in the Navy but not if the patient is a Special Forces member in the Navy. Special Forces members may be approved only for PRK.

It is not the responsibility of the optometrist to know all of the different parameters for each branch of the military, but it is their responsibility to advise the patient to go and find out for themselves which refractive surgery options are allowable and which aren't. Proper documentation in the chart that this information was given to the patient is required.

Below are the most currently available links to the public information regarding refractive surgery in the Army, Navy and Air Force. In general, subject to change and not necessarily firmly set in stone, here are some ground rules:

* Contact Lenses are NOT permitted
* PRK is accepted by a wider range of programs than LASIK
* -8.00 to -10.00 of sphere is approximately the upper limit for myopia
* Special Forces have much different requirements than non-SF
* ALWAYS have a service member get clearance
* Prior incisional refractive surgery like RK is disqualifying
* Pilots and aircrew have much different requirements than non-pilots and non-aircrew
* Implantable Phakic Collamer Lenses (ICLs') are permitted on a case by case basis.
* +3.00 of sphere is approximately the upper limit for hyperopia (there are some branches that do not allow hyperopia)
* Low levels of cylinder (under 2.50D) are strongly preferred over higher levels of astigmatism
* Monovision is generally not recommended and disqualifying for pilots or aircrew
* One wrong procedure can end a career

Custom LASIK/PRK is strongly preferred over conventional
* Myopes are preferred over hyperopes
* Enhancements are permitted on a case by case basis
* Waivers are required for most refractive surgery procedures
* Bladeless LASIK is preferred over bladed LASIK
* Keratoconus is disqualifying

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It’s wonderful to feel truly excited about a new development in your field, and I must say I’m feeling this way about the FDA approval of the first ever accommodative/astigmatism correcting IOL in this country—the Trulign Toric. Now while many of you may be thinking, “Dr. Salib, you really need to get out more often,” let me explain why this really caught my attention.

The good and bad thing about our FDA is that it takes its time approving new technologies. For example, unlike surgeons here, our colleagues in Europe have enjoyed the advantages of the Alcon Restor Toric IOL now for quite a few years. Up until now, the choices we had for premium IOL’s included toric, accommodative, and multifocal IOL’s. The toric IOL’s are astigmatism correcting. The Accommodative IOL’s have flexible hinges, affording good distance and intermediate vision (with some near vision), such as the Crystalens. Multifocal IOL’s split the light rays to give good distance and near vision (with some intermediate vision), such as the Alcon Restor and the Tecnis Multifocal.

However, astigmatism correction and accommodation within the same IOL was never before approved in this country. If anyone had ≤1.5 D of astigmatism and wanted a broader range of vision, I would suggest either the Crystalens or the Restor IOL, but I would correct for any astigmatism with Limbal Relaxing Incisions (LRI) either done by hand or with the aid of the precise LenSx laser during cataract surgery. I routinely use the LenSx laser for this purpose, and it certainly has increased patient satisfaction, not only for the wow factor of using a laser during cataract surgery, but also for the benefits of decreased astigmatism, tailor made incisions and capsulotomy’s, as well as breaking up the cataract so that less energy is used during phacoemulsification (and therefore faster healing times since less corneal endothelial cells are being damaged).

If the patient had >1.5-2.0 D of astigmatism, I could only offer them the toric IOL since LRI’s do not routinely and reliably correct astigmatism beyond that amount. (If a Restor or Crystalens patient is left with ≥0.75-1.0 D of astigmatism, the resulting blur without glasses tends to leave them unhappy, necessitating correction with refractive surgery, glasses or contact lenses.) If a toric IOL patient wanted to minimize their use of glasses postoperatively, they were offered surgical monovision or monovision with a contact lens.

Now enter the Trulign Toric IOL, the only lens available in this country that can correct for astigmatism AND accommodate! The Trulign Toric was approved by the FDA in May 2013. It basically has all the benefits of the Crystalens while also correcting for astigmatism. Cylinder correction options range from 1.25-2.75 D (0.83-1.83D at the corneal plane)—a range that meets the needs of 90% of astigmatic cataract patients. If you combine this with the LenSx laser, you can reliably correct up to approximately 3.0-3.5 D of astigmatism. This certainly opens up the doors of possibility to many patients who want a broader range of vision.

The IOL itself looks just like the Crystalens but also has axis marks on the anterior surface to align these marks with the steep axis, correcting for the astigmatism. In my surgical patients, you will often find LenSx made LRI’s on this same axis to fine tune the astigmatism correction. The optic is aspheric for minimal inducement of higher order aberrations, is made of silicone and now has enhanced UV protection.
Clinical studies have shown remarkable results with 86.6% of patients achieving uncorrected intermediate visual acuity of 20/25 or better. It was well tolerated; 99.2% of patients reported no significant visual disturbances. Since it is a clear optic, it lets in 100% light, working well under different lighting conditions while also minimizing glare and halos.

So who is the ideal candidate for this lens? The Trulign Toric IOL is designed for seniors with active lifestyles who desire to minimize their dependence on glasses after cataract surgery and who have up to approximately 2D of astigmatism (up to 3.5D if LRI’s are performed). Patients need to have realistic expectations when choosing this lens. I always tell them this lens gives great distance/intermediate vision, but they will likely need glasses for smaller print. It is important to stress that there are no guarantees since every person’s eyes heal differently, and that this lens is meant to decrease their dependence on glasses, not necessarily to get rid of them. When implanting accommodative IOL’s in a patient’s eyes, I usually aim the dominant eye for plano to -0.25 and the nondominant eye for -0.25 to -0.50. That combination has yielded excellent results, even for near vision, and many happy patients.

I have already implanted some of these Trulign IOL’s, and I am looking forward to helping more patients to achieve the vision and independence they want through these IOL’s. This, combined with the LenSx laser, provides an excellent combination of precision and functionality. Now you can see why I am so excited about this!

For more information or to refer a patient for surgical evaluation, please do not hesitate to contact me at the Orange County Eye Institute at 949-770-1322 or visit my website at www.oceyeinstitute.com.
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The Investors’ Dilemma is a cycle that explains why many investment decisions are driven by emotions and instincts. On the one hand, investors want to accumulate enough capital to fund their most important goals. Yet, for most, this will only happen by investing money prudently. Therefore, investors need to make decisions and select strategies to maximize investments year after year. Unfortunately, the actions investors frequently take are likely to be self-defeating. Let’s look at how each step of this counter-productive cycle interferes with an investor’s ability to develop and maintain an ideal investment strategy.

1. Fear of the Future
The cycle begins with a sense of uncertainty about the future. Uncertainty causes fear. Questions are prevalent: “Will there be enough money to maintain my standard of living? How much do I need to save? How do I know what the best investments are? What is the stock market going to do in the future?” The media and advertisers prey upon this fear of the future in an effort to sell products.

2. Forecasting the Future
Because of this fear of the future, investors have a strong desire to comprehend and predict future events...if someone could tell what is going to happen with inflation, long-term interest rates, stock prices, overseas markets...then there would be nothing to fear. Along these lines, investors are frequently convinced that someone has the information, power and insight to forecast the future. After all, Wall St. and the media spend billions of dollars each year trying to convince us that they can do these things.

3. Track Record Investing
The primary method investors employ to convince themselves that the future can be foretold is called Track Record Investing. This means they look for fund managers who have performed better than the market in the past, and hope that they will continue to have superior performance in the future. In just about every other area of life, past performance matters. However, in investing, past performance has zero correlation with future results.
4. Information Overload
In the past, gathering information was the best way to guide prudent investment decisions. However, the current Information Age has created access to so much information that it is easy to become overloaded. In the quest to find the right investments, investors feel compelled to expose themselves to all available information: internet, books, newspapers, magazines, TV talk shows, advertisements, friends’ experiences, etc. Indeed, instead of reducing fears and doubts about investment decisions, this deluge of information often intensifies them.

5. Emotion Based Decisions
As investors we never overcome our own humanity. Even though most investors prefer to think that they make investment decisions based upon logic, it is typically emotions, such as trust, loyalty, hope, greed, and fear that drive investment decisions.

6. Breaking the Rules
There are three commonly accepted rules of investing: 1) Own equities; 2) Diversify; 3) Rebalance. The golden rule of investing is: Buy when prices are low and sell when prices are high. It sounds simple. However, when investors base decisions about the future on the past, and are overcome by their emotions, they wind up breaking the rules, thereby sabotaging their portfolios.

7. Performance Losses
Performance loss means investors fail to capture the returns they expected. Unfortunately, because investors so frequently break the rules of investing, they receive disappointing rates of return on their money. When this effect is compounded over a period of years, wealth potential for reaching financial goals is significantly decreased. Such loss creates additional frustrations and fears about the future, once again initiating this vicious and recurring cycle.

**The Result: Not Enough Money**
In the end, the result of The Investors’ Dilemma is people don’t have enough money to accomplish their most meaningful life goals and dreams. Not only are they not where they want to be financially, but they have also spent a large portion of their lives suffering stress, anxiety, concern and fear.

**Ending the Investors’ Dilemma**
Focus on maintaining a long-term approach to investing. Don’t focus on the next 2 months or even the next 2 years. Focus on the long haul. In the end, the daily fluctuations of the market are just noise.

Use structured or index type of mutual funds for your investments. Traditional actively managed mutual funds have not delivered on their promise to consistently beat the market. Therefore, it doesn’t make sense to own them when more cost effective alternatives are available.

Tune out the media when it comes to your investments. The media’s job is to get viewership, which they do by playing on investors’ emotions.

Find an investment advisor to work with who will educate you on investing and coach you to remain disciplined.
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When LA Magazine asked 31,000 doctors "Who would you choose as your doctor?" only two vitreo-retinal specialists in Long Beach and Orange County were named by their peers from 2010 through 2012

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