

# A practical guide to vision rehabilitation practice

Access to comprehensive low vision rehabilitation services is growing, notes Jerry P. Davidoff, O.D., chair-elect of the American Optometric Association Vision Rehabilitation Section (AOA-VRS). AOA survey data indicate more optometrists are providing care for visually impaired patients in their practices—or at least are readily prepared to refer patients for low vision care when the need arises. More than a third (36.2%) of the optometrists responding to the 2006 AOA Scope of Practice

Enhanced professional education and improved corrective devices are making vision rehabilitation more practical for general optometric practices as well as the growing roster of dedicated low vision rehabilitation clinics and rehabilitation agencies around the nation.

Survey reported providing some low vision rehabilitation services to patients. One quarter (25.4%) reported that they accept low vision rehabilitation referrals from other practitioners. More than 4 of 5 (84.6%) optometrists said that although they may not personally be prepared to provide all the low vision rehabilitation services that a patient might require, they do regularly refer patients for low vision rehabilitative services elsewhere. Some 175 full-service low vision rehabilitation centers have now been opened around the nation, Dr. Davidoff estimates. That includes the 54 opened over the last few years by the U.S. Department of Veterans Affairs in VA Medical Centers.

However, with the population aging and vision impairment threatening to become a major national health crisis, access to low vision rehabilitation still is not adequate, Dr. Davidoff maintains. As a result, many patients with impaired vision may not be realizing the benefits today's low vision care and assistive devices can provide.

"I was in the airport coming back from Toronto just the other day when a man approached me and, somewhat embarrassed, asked if I could help him read his airline ticket. He said he did not have his contact lenses; however, he later admitted he had Staargardt disease," recalls

Dr. Davidoff. "No one had told him that he could benefit from any number of new low vision devices, some of which can even fit in your shirt pocket." Despite the results of the AOA survey, Dr. Davidoff reports, he all too frequently encounters people with visual impairments who could benefit from state-of-the-art low vision care but who apparently have never been made aware of it.

To help improve access to low vision rehabilitation and up-to-date low vision technology, the AOA-VRS is encouraging optometrists and optometry students to consider providing low vision rehabilitative care either as part of a general practice or in a specialized low vision rehabilitation setting, or make it a firm policy to promptly refer visually impaired patients for such care. Virtually any practice can provide at least some basic vision rehabilitation services, Dr. Davidoff contends, because every practice has the expertise, basic equipment, space, and other resources necessary. True, many optometrists refrain from providing low vision care because they feel it may be time consuming, unprofitable, difficult to obtain reimbursement for, or "depressing," Dr. Davidoff acknowledges. However, thanks to new professional education programs such as the AOA-VRS's Low Vision University (LVU) course, more practitioners are overcoming such problems and are more actively providing services for the visually impaired—or at least know enough to properly refer. In 2010, LVU will transition to a new program titled "Preventing Age-Related Vision Loss: Medical Treatment, Ocular Nutrition and Vision Rehabilitation."

The AOA, the American Academy of Ophthalmology, and the National Eye Institute have all launched efforts to increase awareness of low vision rehabilitation among medical doctors and other health care providers. With February recognized as both Age-Related Macular Degeneration Awareness Month and Low Vision Awareness Month, it may now be an appropriate time for optometrists to consider expanding the availability of low vision rehabilitation services through their practices, Dr. Davidoff suggests.

All licensed optometrists have the clinical knowledge necessary to provide low vision care, Dr. Davidoff emphasizes. "It involves the same knowledge of optics that would be utilized day to day when prescribing any other lenses, just applied in a slightly different manner," he notes. And although not all optometrists have served a rotation in a low vision rehabilitation center while in school, he acknowledges, any practitioner can develop greater expertise in low vision rehabilitation, greater familiarity with the range of

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low vision devices, and an appreciation of low vision practice management, he says. The AOA-VRS Low Vision University Course, introduced 3 years ago, provides a detailed format for a comprehensive low vision examination (including low vision patient history, refraction, magnification and minification options, rehabilitation options, and eye health examination), with suggestions on developing a rehabilitative care team for the patient, an overview of coding and billing issues, a review of low vision devices, and other helpful information, Dr. Davidoff notes. The AOA-VRS Low Vision Student Awareness program also provides a similar if somewhat less detailed overview for optometry students. The American Academy of Optometry, AOA's Optometry's Meeting<sup>®</sup>, Lighthouse International, and various other national, regional and state optometric organizations and meetings offer courses that can be used to provide or supplement expertise in the care of low vision patients. The newly expanded AOA-VRS Web site also provides convenient access to a compendium of low vision articles and other documents, he adds.

Practitioners generally will find they have most all of the ophthalmic equipment required for entry into a vision rehabilitation practice, Dr. Davidoff notes. The only additional requirements might be:

- Special eye charts. For distance, instead of the usual Snellen chart, low vision examinations are sometimes best conducted using the Early Treatment Diabetic Retinopathy Study (ETDRS) or Distance Test Chart for the Partially Sighted (Designs for Vision). For near, various single letter or number charts as well as sentence or paragraph charts can be of value.
- A tape measure to determine the distance "from patient to task," that is, the distance from the patient's eyes to, for example, a medicine bottle label or a television screen.
- Supplemental lighting that may be necessary to allow a patient to see the examination charts and maneuver around the office. In addition, a range of supplemental lights in the office can help the practitioner easily and graphically illustrate to the visually impaired patient (and others) the difference fluorescent, halogen, or high intensity lights could make in improving visibility in the home or workplace.

Practitioners should be aware that the office should be bright, easy to navigate, and accessible to the handicapped, Dr. Davidoff emphasized. In most cases, in addition to supplemental lighting, new brighter nonreflective wall paint, some rearranging of the furniture, and perhaps a wheelchair ramp may be necessary. Such improvements can make a difference for patients who are likely to need vision rehabilitation, he emphasizes.

Traditionally, comprehensive low vision rehabilitation required considerably more office space than other types of practice, Dr. Davidoff acknowledges, largely because practitioners need to keep an inventory of low vision devices on hand. However, today, especially for those who are just beginning to get involved in vision

rehabilitative care, that is not necessarily the case. Developments in low vision technology over recent years have resulted in not only higher quality vision enhancement devices, but smaller ones. Some electronic devices with variable magnification can now do the work of multiple systems. Any practice can find the space necessary for a small inventory of magnifiers (and perhaps even distance devices such as telescopes), Dr. Davidoff says. Moreover, virtually any practice can afford a basic inventory of handheld low vision devices, he says.

## Developing referrals

Dr. Davidoff reports that he often receives referrals from both optometrists and ophthalmologists in both the clinic and private practice where he offers low vision rehabilitation services. However, developing a care team or referral network remains one of the more challenging aspects of vision rehabilitation practice, Dr. Davidoff acknowledges. Some eye care practitioners will not refer patients for vision rehabilitation services because they fear the patients will not be referred back to them.

"Report letters" issued to referring practitioners at the conclusion of low vision rehabilitation can be an important element in developing a cooperative, coordinated approach to the care of visually impaired patients, Dr. Davidoff believes. He makes it a practice to always send the referring practitioner a report detailing the results of the examination, follow-up rehabilitation care, and adaptive devices provided to the patient for inclusion in the patient's records. The report will also indicate that the patient has undergone all of the rehabilitative training appropriate at the time.

Patients themselves can be an important source of referral in a low vision rehabilitation practice, Dr. Davidoff said. "If you help a visually impaired patient, particularly a severely impaired patient, that patient is good at getting the word out" through conversations with friends and relatives, he said. "I know I certainly receive more new patients through word-of-mouth referrals by existing patients than through referrals from other health care practitioners."

## Reimbursement

Reimbursement levels and potential problems in claim filing are often concerns for optometrists considering low vision practice. Most low vision patients are older adults, often covered under Medicare. Medicare generally will cover at least some elements of the low vision rehabilitation care process. However, practitioners should adhere carefully to all applicable Medicare claim filing rules. (The Low Vision University Course offers a detailed review of coding for low vision services.) Low vision practitioners should also be aware that Medicare coverage varies somewhat from carrier to carrier, so it is also important to check with local carriers regarding coverage policies before filing any claims.

In the majority of cases, Medicare will not cover all of the expenses associated with low vision rehabilitation. Notably, the refraction, the magnification evaluation, and the low

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