

OUTPATIENT BLIND AND VISION REHABILITATION CLINIC PROCEDURES

- 1. REASON FOR ISSUE.** This Veterans Health Administration (VHA) Handbook defines Blind and Low Vision Outpatient Clinics in Blind Rehabilitation Service and describes the procedures for the provision of interdisciplinary outpatient blind and vision rehabilitation and coordination of care.
- 2. SUMMARY OF CHANGES.** This is a new Handbook for programs that have been established since 2008.
- 3. RELATED ISSUES.** VHA Directive 1174 (to be published), and VHA Handbook 1174.2.
- 4. RESPONSIBLE OFFICE.** The Office of Patient Care Services, the Chief Consultant, Rehabilitation Services (10PR) is responsible for the contents of this VHA Handbook. Questions may be referred to the Director, Blind Rehabilitation Service (10PRB) at (202) 461-7355.
- 5. RESCISSIONS.** None.
- 6. RECERTIFICATION.** This VHA Handbook is scheduled for re-certification on or before the last working day of July 2016.

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OUTPATIENT BLIND AND VISION REHABILITATION CLINIC PROCEDURES

1. PURPOSE AND AUTHORITY

a. This Veterans Health Administration (VHA) Handbook defines Outpatient Blind and Vision Rehabilitation Clinics under VHA Blind Rehabilitation Service, and describes the procedures for providing interdisciplinary outpatient blind and vision rehabilitation. The Department of Veterans Affairs (VA) Executive Decision Memorandum (362194) titled “Continuum of Care for Visually Impaired Veterans,” signed by the Under Secretary for Health in 2006 approved the establishment of the clinics. Authority for their establishment is derived from Title 38 United States Code (U.S.C.) 1710, 38 U.S.C. 1706, and Title 38 Code of Federal Regulations (CFR) 17.38

b. Those individuals for whom these training services are available include visually-impaired Veterans and Servicemembers, as well as their families and caregivers.

2. BACKGROUND

a. VA estimates there are more than 1 million visually-impaired Veterans over the age of 45 in the United States. Within this group, approximately 157,000 are legally blind, and 1,026,000 have low vision. About 80 percent of visually-impaired Veterans have a progressive disability caused by age-related macular degeneration, glaucoma, or diabetic retinopathy.

b. In 2008, Blind Rehabilitation Service, together with the Veterans Integrated Services Network (VISN) administration and the Visual Impairment Advisory Board (VIAB), established 55 new outpatient blind and vision rehabilitation clinics. These clinical programs were designed to serve Veterans and Servicemembers who are visually impaired, but not yet severely disabled. The services are an important expansion of the continuum of care for patients who have been identified in eye clinics as having vision loss that has degraded independence and quality of life.

c. The plan for the expanded continuum of care was conceived in 2002 by the VIAB, a group of subject matter experts in rehabilitation, eye care, visual impairment and blindness, research, and VA administration. This group was formed as a result of the recommendations of a Gold Ribbon Panel to study visual impairment among Veterans as a part of VA’s Capital Asset Realignment for Enhanced Services (CARES) initiative. The VIAB drafted the Executive Decision Memorandum, completed a gap analysis to discover where services were required, and convened a resource cost workgroup to recommend responsibilities, staffing, and costs for each level of vision rehabilitation care.

d. The expanded plan was approved in 2006, and announced by the Secretary of Veterans Affairs in 2007. Full funding for the expansion was allocated. Under the reorganization plan, VHA Blind Rehabilitation Service (BRS) and each VISN partnered to provide rehabilitation care for all Veterans with visual impairments, as well as Servicemembers referred for care.

e. Basic low-vision services are to be available at all VA eye clinics, and every VISN offers intermediate and advanced low-vision services. All VISNs without an inpatient blind rehabilitation center were provided funding for an outpatient blind rehabilitation clinic.

3. MISSION

The mission of each blind and vision rehabilitation clinic is to enhance the independence and quality of life of Veterans and Servicemembers who have experienced vision loss, and to restore their roles in their families and communities. Professional staff assists individuals in the development of personal independence, quality of life, and their integration within the family and community. Each clinic provides comprehensive and individualized adjustment programs in a therapeutic atmosphere where privacy, dignity, personal values, and emotional needs of the patient and their families are recognized and respected. This is accomplished through:

- a. Effective and efficient delivery of rehabilitation,
- b. Partnership with VHA eye care to ensure Veterans' maximum use of visual capabilities,
- c. Patient and family education,
- d. Case management through partnership with VHA Social Work and Care Management,
and
- e. Professional training for blind and vision rehabilitation professionals.

4. DEFINITIONS

a. **Blind Rehabilitation Outpatient Specialist (BROS).** A BROS is a multi-skilled university trained (Bachelor's or Master's Degree in Blind Rehabilitation) and experienced blind rehabilitation instructor who has advanced technical knowledge and competencies at the journeyman level in at least two of the following disciplines: orientation and mobility (O&M), living skills, manual skills, and visual skills. The BROS has been cross-trained to acquire broad-based knowledge in each of these disciplines, along with knowledge of computer access training (CAT). BROSs are VA 601 series professionals who practice under Hybrid Title 38 qualification standards.

b. **Blind Rehabilitation Specialist.** A Blind Rehabilitation Specialist is a VA position title that refers to the blind or vision rehabilitation staff that assesses, plans, and instructs in one of the blind or vision rehabilitation disciplines. It designates an instructor, therapist, or case manager with a Bachelor's, Master's, or higher degree in one or more of the specialized areas of working with persons who are visually impaired; or a professional who possesses a Bachelor's, Master's, or higher Degree in an allied health profession with expertise in one or more of the specialized areas of working with persons who are visually impaired. Blind Rehabilitation Specialists are VA 601 series professionals who practice under Hybrid Title 38 qualification standards. The following therapists, instructors, and case managers within the VHA system are Blind Rehabilitation Specialists:

- (1) O&M Specialists,
- (2) Low-vision Therapists,

(3) Vision Rehabilitation Therapists (formerly known as Rehabilitation Teachers for the Blind),

(4) Manual Skills Instructors,

(5) CAT Instructors, and

(6) Visual Impairment Services Team (VIST) Coordinators.

c. **Computer Access Training (CAT)**. CAT is the instruction of a visually-impaired person to use specialized access equipment necessary to independently operate computers. This includes evaluating and training the patient to use large print, synthetic speech, and/or Braille access devices in order to perform basic computer operations and maintenance.

d. **Continuum of Care for Visually Impaired Patients (see Appendices A and B)**. Continuum of Care for visually-impaired patients refers to vision and blind rehabilitation services ranging across multiple levels of care, including: basic outpatient low vision care provided by licensed eye care practitioners; intermediate and advanced outpatient low-vision care involving a team of licensed eye care practitioners and rehabilitation professionals; outpatient blind rehabilitation services; and inpatient blind rehabilitation services. Services may be provided in the patient's home and community, and case management screening of psychosocial needs, information, and referral to VA and community resources and adjustment counseling. Patients are referred to the type program that best matches their functional needs.

e. **Excess Disability**. Excess disability refers to problems and task performance difficulties related to vision loss that significantly impacts the person's functional independence or personal safety, and that are out of proportion to the degree of visual impairment as measured by visual acuities or visual fields.

(1) Veterans whose vision is better than legal blindness may have excess disability due to:

(a) Sudden and/or traumatic visual disorder (especially related to military service);

(b) Disabling co-morbidities (e.g., hearing impairment, mobility impairment, etc.);

(c) Systemic diseases that cause fluctuating visual impairment;

(d) Combined losses of other vision functions (e.g. contrast sensitivity, visual field loss that is less than legal blindness, stereopsis, etc.);

(e) Sudden changes in caregiver status; or

(f) Other reasons.

(2) A designation of excess disability is recommended by the patient's VIST or the provision of care in an inpatient program, in home or community, and case management provided by a VIST Coordinator.

f. **Legal Blindness.** Legal Blindness is when the best corrected central visual acuity in the better-seeing eye is less than or equal to 20/200, or the visual field dimension in the better-seeing eye is less than or equal to 20 degrees at the widest diameter, even if central visual acuity is better than 20/200.

g. **Licensed Eye Care Practitioner.** A licensed eye care practitioner is a professional who is licensed to provide eye examinations, treat visual problems, and prescribe optical corrections i.e., an Optometrist or Ophthalmologist.

h. **Living Skills.** Living skills refers to the instructional area that addresses the skills necessary for an individual to manage a broad range of daily activities, including: personal grooming, eating skills, food preparation, household management, and communication skills such as Braille, keyboarding, handwriting, and reading with the use of electronic scanners.

i. **Low Vision Clinical Examination.** A low-vision clinical examination is a comprehensive eye examination that evaluates a visually-impaired person's clinical visual functions, provides best optical corrections, and determines the patient's ability to benefit from adaptive vision training and prescriptive optical low-vision devices. This examination is usually performed by an Optometrist or Ophthalmologist with a special interest in low-vision evaluation and training.

j. **Low-Vision Therapy.** Low-vision therapy is the instructional area that addresses the needs of persons with vision that is still sufficient for daily functioning. Low-vision therapy enables Veterans to gain a better understanding of their eye problems, and instructs them in effective use of their remaining vision through techniques that improve visual perceptual and visual motor function for daily tasks.

(1) This visual skills training includes:

(a) Assessment of the tasks that require using vision;

(b) Planning an interdisciplinary rehabilitation program to meet the patient's goals for using vision; and,

(c) Providing intervention with visual techniques, special low-vision devices, and ergonomic enhancements designed to promote the use of vision to meet the patient's goals.

(2) The patient's goals may include, but are not limited to: literacy and numeracy, activities of daily living (ADL), orientation to the environment, home care and repairs, and vocational and avocational pursuits.

(3) Low-vision therapy includes techniques to assess and compensate for situations in which relying on vision is not the safest or most efficient mode.

k. **Manual Skills.** Manual skills refers to the instructional area designed to enhance skills in sensory awareness with an emphasis on adaptive and safety techniques. Skill training focuses on organization, tactual awareness, eye-hand coordination, spatial awareness, visual skills, memory sequencing, problem solving, and confidence building. Activities range from basic tasks using hand tools, to advanced tasks using power tools and woodworking machinery.

l. **National Program Consultant.** A National Program Consultant is a representative of the Director, BRS, to the field, the Consultant provides ongoing support and consultative services to the VHA outpatient low vision and blind clinics, inpatient blind rehabilitation centers, BROS, and VISTs.

m. **Ocular Health Examination.** An Ocular Health Examination is an examination conducted by a licensed eye care practitioner that identifies the level of, and reasons for, a person's visual impairment. The examination provides the licensed eye care practitioner with information essential to conducting and/or directing additional assessments and management strategies.

(1) The examination includes:

(a) A refraction to establish best-corrected central visual acuities (not using a preferred retinal locus);

(b) A thorough assessment of the visual system and ocular health to establish the diagnosis primarily responsible for the impairment; and

(c) Ensurance that all ocular and visual disorders are being appropriately managed.

(2) If there is a significant visual field loss, a Goldmann Perimeter, Humphry Visual Field Analyzer, or equivalent, is used to determine the extent of the field loss.

n. **Optical Low-Vision Devices.** Optical low-vision devices are devices that optically alter, through the use of lenses or other technology, the image focus, size (magnification or minification), contrast, brightness, color, or directionality of an object. Such devices include, but are not limited to: habitual prescriptive spectacles (with or without tint), microscopic spectacles, hand-held magnifiers, stand magnifiers, telescopes (monocular or binocular), head borne lenses, minifiers, prisms, closed circuit televisions (CCTVs), and electronic optical enhancement devices (EOEDs).

o. **Orientation and Mobility (O&M).** O&M refers to the instructional area that addresses establishing and maintaining orientation to the environment, and moving safely in the environment in an efficient and confident manner. In O&M, Veterans use all remaining senses, available environmental information, and protective techniques and devices.

p. **Visual Impairment Center To Optimize Remaining Sight (VICTORS).** VICTORS is a short-term optometric low vision rehabilitation program for visually-impaired Veterans. There are currently three VICTORS programs: Lake City, FL, Northport, NY, and Kansas City, MO.

q. **Visual Impairment Services Outpatient Rehabilitation (VISOR)**. VISOR refers to a VA medical center outpatient blind rehabilitation clinical program. Eleven VISOR programs were established in 2008 as a rollout of the blind rehabilitation continuum of care. The original program upon which the new programs were based is located at the VA Medical Center in Lebanon, PA.

r. **Visual Impairment Services Team (VIST)**. VIST is a team comprised of health care and allied health care professionals with responsibility to ensure that severely-disabled visually-impaired Veterans are identified, evaluated, and provided health and rehabilitation services to maximize adjustment to sight loss. VIST representatives may include, but are not limited to: social work, ophthalmology, optometry, prosthetics, primary care, vocational rehabilitation, library service, nursing, audiology, podiatry, nutrition, psychology, Veterans Benefits Administration (VBA), blind Veterans' consumer organizations, blind consumers, and state and/or community agencies for persons who are visually impaired.

s. **VIST Coordinator**. The VIST Coordinator is the case manager who has responsibility for the coordination of services for severely-disabled visually-impaired Veterans and their families. The VIST Coordinator is often the entry point into the continuum of care.

5. SCOPE

The BRS system of care provides an integrated, lifelong continuum of services for eligible Veterans and Servicemembers with visual impairment. This system of care provides key components of service to Veterans through outpatient clinics, home and community, intensive inpatient care, and lifetime care management for patients who are severely disabled from visual impairment. BRS partners with Primary Care, Optometry, Ophthalmology, Care Management and Social Work Service, Vocational Rehabilitation and Employment, Physical Medicine and Rehabilitation, the Polytrauma System of Care, Audiology, Nursing, Prosthetics, and other departments at the national and local levels to ensure the best care for patients with visual impairment.

6. NATIONAL SYSTEM OF BLIND AND VISION REHABILITATION

The BRS system of care is an integrated network based on tiered levels of care (see App. A and App. B) designed to coordinate severity of functional disability with the appropriate intensity of rehabilitation. Local access to VA eye clinics (optometry and ophthalmology) that offer basic low vision services enables most visually impaired Veterans to be identified and referred into the BRS continuum of care. Once a visually impaired Veteran is identified as needing care, a decision-making algorithm is utilized by VA staff to determine the appropriate level of care to refer a Veteran for needed services (see App. A). Appendices C, D, and E describe the rehabilitation provided at each level in detail; Appendices F, G, and H provide sites of all clinical programs. Any proposed changes to the placement, staffing, and services provided in outpatient blind rehabilitation clinics described in this Handbook require approval by the VIAB.

7. RESPONSIBILITIES OF THE VISN DIRECTOR

The VISN Director provides critical support for the continuum of care within each VISN, balancing needs for responsiveness and timely and full access to care with consistency and coordination of services. Each VISN Director is responsible for:

- a. Ensuring that for the VISN, there is an updated plan of rehabilitation care for visually-impaired Veterans;
- b. Ensuring that medical facilities adhere to the agreement with VHA BRS that established the placement, services, and resources required for vision and blind rehabilitation clinical programs within the VISN (see App. I).
- c. Facilitating the smooth and efficient transfer for care between VA facilities, and to regional inpatient blind rehabilitation centers whenever necessary; and
- d. Supporting all components and services in the vision and blind rehabilitation continuum of care described in this and other BRS Handbooks (see par. 21).

8. RESPONSIBILITIES OF THE FACILITY DIRECTOR

The Facility Director at a facility housing a vision or blind rehabilitation clinic is responsible for:

- a. Ensuring that low vision and blind clinic staff are providing care commensurate with that described in the VISN's Memorandum of Understanding (MOU) with BRS (see Apps. C, D, and E for descriptions of care provided and App. I, the Executive Decision Memorandum establishing the clinics).
- b. Ensuring that resources are available to provide staff, equipment, supplies and space to house the program commensurate with recommendations from the VIAB, and included in the VISN's MOU with BRS, and that resources are available for the continuing education of staff.
- c. Ensuring that the low vision or blind rehabilitation clinic is organizationally aligned under the Chief of Staff.
- d. Obtaining the concurrence of the Director, BRS (10PRB), in the selection of an VISOR Chief.
- e. Ensuring that any necessary eligibility determinations as required by the VA facility housing the clinic are conducted; e.g., VA Form 10-10EZ, Application for Health Care Benefits, VA Form 10-10EZR, Health Benefits Renewal Form (Fillable), Hospital Inquiry (HINQ), Rating Decision Form), etc.

f. Ensuring that an eye examination progress note, or a summary documenting the functional visual impairment of the Veteran (signed by a licensed, credentialed eye care practitioner) is provided, from which the following can be readily derived:

- (1) The diagnosis responsible for the vision loss,
- (2) The best corrected central visual acuity of each eye, and
- (3) The visual field of each eye.

g. Ensuring provision of pertinent patient information, including: the Veteran's name and identifying information, type of clinic referral for which an application is submitted, description of any significant problems or unique circumstances presented by the patient, identification of the referring individual and the referring facility.

h. If the Veteran has been evaluated or trained by other clinics or professionals in the BRS continuum of care, ensuring that reports of such are provided prior to acceptance in the outpatient clinic.

i. Ensuring that referrals of Servicemembers are submitted by program case managers at Military Treatment Facilities or VHA Polytrauma Rehabilitation Centers, and that referrals comply with processes outlined in the current "Memorandum of Agreement Between Department of Veterans Affairs and Department of Defense for Medical Treatment provided to Active Duty Service Members with Spinal Cord Injury, Traumatic Brain Injury, Blindness, or Polytrauma Injuries." *NOTE: VIST Coordinators can assist in this process.*

j. For Servicemembers, ensuring a summary report is provided from the referral source describing the individual's vision-related functional or adjustment problems.

9. RESPONSIBILITIES OF THE OUTPATIENT LOW-VISION CLINIC SUPERVISOR OR THE VISUAL IMPAIRMENT SERVICES OUTPATIENT REHABILITATION (VISOR) CHIEF

The outpatient low vision rehabilitation clinic supervisor or VISOR Chief is responsible for:

a. Ensuring that effective, efficient vision or blind rehabilitation is provided to eligible Veterans and Servicemembers;

b. Recruiting, hiring, and promoting qualified staff;

c. Overseeing surveillance and accreditation by the Commission on Accreditation of Rehabilitation Facilities (CARF) and Joint Commission;

d. Ensuring complete data entry into the Blind Rehabilitation National Database for the status of each application received in the clinic (see Table 1, subpar. 15f);

e. Notifying the referring source when additional information is needed in order to confirm the appropriateness of the Veteran for the clinic program (see Table 1, subpar. 15f);

- f. Consulting with the referring source when a review of a referral indicates that the Veteran is not appropriate to participate;
- g. Ensuring that the application is returned to the referring source, with notification sent to the National Program Consultant, if a referral is cancelled due to receipt of an incomplete application;
- h. Ensuring that the clinic's licensed eye care practitioner reviews the referral to confirm the Veteran's vision loss;
- i. Ensuring that ocular and vision data documented in the eye examination is consistent with loss of function in daily life;
- j. Ensuring that the functional goals of the patient can be addressed by the clinic program;
- k. Ensuring that the Veteran's medical and psychological status is sufficiently stable to maximize the Veteran's potential to benefit from the program; and
- l. Ensuring that each patient's family members or other caregivers are included in the clinical program planning and implementation.

10. RESPONSIBILITIES OF THE VIST COORDINATOR

The VIST Coordinator is responsible for:

- a. Assessing needs;
- b. Providing and/or arranging for the provision of appropriate rehabilitation services and devices in order to enhance a Veteran's functioning level; e.g., referrals to outpatient low-vision clinics, outpatient clinics, BRCs, BROS, and/or outsourced services;
- c. Identifying new cases of severe visual impairment;
- d. Providing professional counseling;
- e. Meeting specific objectives established by the VIST;
- f. Arranging VIST Reviews; and
- g. Conducting educational programs relating to VIST and blindness.

11. AUTHORIZED OUTPATIENT REHABILITATION SERVICES.

- a. **Rehabilitation Care.** Blind and vision rehabilitation episodes of care (EOCs) are authorized. An EOC may be defined as the set of services required to manage a specific condition over a defined period of time. In the BRS outpatient clinics, an EOC includes:

(1) **Pre-admission Care.** Each patient receives information concerning the program, application status, admission date, patient rights and a description of the services to be provided.

(2) **Assessments, Examinations, and Evaluations**

(a) Each patient receives an intake interview in order to develop a problem list of functional difficulties caused by visual impairment. The intake is followed by full interdisciplinary assessments and evaluations of the use of vision and other learning modalities related to the Veteran's problems and goals. To avoid fragmented care, continuous communication, interdisciplinary collaboration, and coordination is critical.

(b) An assessment is conducted in each of the blind and vision rehabilitation skill areas appropriate to the clinic's level of care as outlined in Appendix C. Assessment and evaluation includes both standardized assessments using formal instrumentation, as well as informal assessments. Assessment and evaluation address the patient's strengths, needs, preferences, and desired outcomes. Assessments and evaluation include information about the Veteran's lifestyle, culture, age, medical condition, cognitive ability, previous training, and future plans. The assessment and evaluation process is continuously updated to ensure best practices and evidence-based rehabilitation care.

(c) Patients are provided ocular health examinations, clinical visual functions evaluation, and treatment services by licensed, credentialed eye care practitioners. Prescriptive optics deemed necessary to maximize the Veteran's vision and rehabilitation are prescribed by a licensed, credentialed eye care practitioner.

(3) **Rehabilitation Planning.** Interdisciplinary teams develop an integrated and coordinated plan of care for each Veteran. The team includes the patient, family or caregiver and professional staff working collaboratively. The plan specifies the problems and rehabilitation goal(s) of the patient and family or caregiver, a description of the planned interventions that the patient is to receive to achieve the goal(s), the patient or family responsibilities in rehabilitation, an approximation of the time the plan requires for completion, and a description of the anticipated outcomes. The treatment plan is individualized to meet the Veteran's needs relevant to lifestyle, age, level of capability, and future plans. Staff continually evaluate performance during the Veteran's rehabilitation program in order to determine the appropriateness of interventions. Any revisions to the treatment plan must be made with the Veteran's involvement. Revisions may be based on demonstrated strengths, changing needs, and desired outcomes in order to ensure that goals remain achievable and meaningful to the patient.

(4) **Interventions**

(a) Blind Rehabilitation Specialists who have demonstrated the required credentials and competencies are authorized to provide blind and vision rehabilitation instruction and training in the clinics. Each clinic provides instruction and training appropriate to the clinical level of care provided (see App. C for descriptions of the levels of care and services provided).

(b) Professional staff provides interventions to assist patients in achieving their goals for independence, quality of life, and family and community integration. Interventions may include, but may not be limited to: new skill development, opportunities for attitudinal changes, learning the use of prescribed optics and other technology, care of technological devices, adjustment counseling, family information and education, as well as ergonomic support and enhancement. Instruction proceeds at a pace that allows the patient to understand the intervention, apply the intervention in practice, rehearse, and apply the intervention in real life situations and environments.

(c) Adjustment counseling is an important intervention that assists Veterans in coping with visual impairment. Various professionals assist visually-impaired Veterans in adjustment to sight loss. Blind Rehabilitation Specialists, who are educated to recognize the social and psychological dynamics of visual impairment, integrate appropriate adjustment strategies into their instruction. Blind Rehabilitation Specialists and eye care practitioners partner with (and refer patients to) VIST Coordinators, social workers, and psychologists to ensure that Veterans' care management, adjustment, and psychosocial concerns are assessed and treated effectively.

(d) Special programs may be offered for Veterans who have completed a previous blind or vision rehabilitation EOC. When eligible patients express an interest in specialized training in a single area to meet a specific need (e.g., new technology), the clinical staff may offer a focused training program designed to meet the identified need, if it is determined to be appropriate.

(e) Veterans may also require a service that does not necessitate a clinical appointment, such as replacement of prosthetic devices, telephone information, and/or counseling, etc.

(5) **Outcomes Assessment and Discharge Planning.** Each Veteran (and family or caregiver when appropriate) is included in an evaluation of relative success in achieving the goals and outcomes specified on the comprehensive rehabilitation plan of care. Veterans and families or caregivers are provided with opportunities to indicate their satisfaction with the program, and may also provide input for program improvement. A discharge plan is developed with the Veteran and family or caregiver to address the final concerns of the Veteran and/or family following an EOC, and to ensure that the Veteran understands:

- (a) Where the Veteran is to receive vision and blind rehabilitation care after discharge;
- (b) Veteran and family responsibilities for any further practice required at home;
- (c) Use and care for any prescribed and recommended prosthetic devices as well as contact information, if ordered prosthetic devices are not received when expected;
- (d) Any referrals to other professionals and information about contacting; and
- (e) Future appointments in the low vision or blind rehabilitation clinic (if any).

b. **Prosthetic Issuance.** Blind Rehabilitation Specialists who have been formally trained to provide instruction with specific prosthetic devices, and who have demonstrated discipline-specific competencies, are authorized to determine a Veteran's need for prosthetic devices. They

may recommend issuance within their scopes of practice after the Veteran demonstrates the ability to effectively use and care for the appliance. Optical low-vision devices are prescribed by a licensed, credentialed eye care practitioner.

c. **Hoptel Lodging.** Facilities housing advanced low-vision clinics and VISOR are authorized to provide lodger or hoptel programs for visually-impaired Veterans. Facilities are required to ensure that Veteran lodgers and any participating caregivers have comfortable, safe, and restful overnight accommodations when required by the geographic distance between the facility and patient's home. Hoptel and lodger programs require a patient to be capable of safely and independently managing self-care, such as transferring, bathing, feeding, dressing, grooming and self-medication; or the patient must have an accompanying caregiver that provides necessary support for these activities.

(1) Lodging must provide sleeping accommodations and bath facilities. Nursing services are not necessarily available, but 24-hour oversight must be provided. Blind or visually-impaired lodgers who are alone may experience critical events such as falls, hypoglycemia, medical urgencies, etc. Therefore, oversight must include the ability for lodgers who are alone to easily and quickly contact a responder who is able to assess critical events and contact emergency medical services when required.

(2) The requirements for safe lodging must be clearly delineated and understood by all parties. Visually-impaired participants and caregivers are provided with:

(a) An orientation to the transportation vehicle (unless it is the patient or caregiver's vehicle), the room, and the lodging environment;

(b) Safety training instruction,

(c) An explanation and accessible copy of all policies and directives related to lodging, and

(d) A review of prescribed and over-the-counter medications by a VA pharmacist.

Education or counseling by VA pharmacy is required if the review shows that current use of combined prescribed and over-the-counter medications is contraindicated for patient safety.

d. **Advanced Educational Training for Professionals.** Each outpatient clinic is authorized to establish affiliations with university programs for the advanced training of practicum students, interns, externs, residents, and fellows in the various disciplines serving the field of blind and vision rehabilitation. These branches of learning may include: O&M, vision rehabilitation therapy, low-vision therapy, and eye care; provided by optometrists, ophthalmologists, eye care technicians, and eye care technologists.

e. **Community Education.** The clinic staff serves as a resource to the VISN, and provides educational in-service programs to internal and external stakeholders.

12. AUTHORIZED OUTPATIENT CLINICAL PROGRAMS AND STAFFING

The following programs coordinated by BRS are authorized as outpatient blind and vision rehabilitation clinics in the continuum of care for visually-impaired Veterans. Minimum staffing patterns to ensure appropriate care are specified (see Apps. A, B, and C for further information related to program organization and responsibilities).

a. **Intermediate Low-vision Clinics.** Clinics are staffed by a minimum of 1.0 Full-time Equivalent (FTE) Blind Rehabilitation Specialist (low-vision therapist), 0.5FTE eye care practitioner, and 0.5FTE program assistant.

b. **Advanced Low-vision Clinics.** Clinics are staffed by a minimum of 2.0 FTE Blind Rehabilitation Specialists (low-vision therapy and O&M), 0.5 FTE eye care practitioner, and 0.5 FTE program assistant.

c. **VISOR.** Clinics are staffed by a minimum of 4.0 FTE Blind Rehabilitation Specialists (low vision, O&M, and living skills), 0.5 FTE eye care practitioner, and 0.5 FTE program assistant.

13. ELIGIBILITY AND PRIORITY OF CARE

VA BRS is committed to serving all eligible Veterans and Servicemembers whose vision loss has created an inability to function effectively in daily life, and who need and can benefit from unique blind and vision rehabilitation services.

a. Priority of care is provided to eligible visually-impaired Veterans, service-connected Veterans rated 50 percent or greater for any combination of disabilities, and Servicemembers who are service-connected for visual impairment.

b. The priority for admission also considers urgent need factors such as:

- (1) Safety issues;
- (2) Medical issues;
- (3) Lack of a caregiver;
- (4) Vocational needs (e.g., attending school, employed);
- (5) Active duty status; and
- (6) Never received blind or vision rehabilitation services.

14. REFERRALS.

The BRS continuum of care has been established so that there is an intermediate low vision clinic, an advanced low vision clinic, and an inpatient or outpatient blind rehabilitation program in each VISN.

a. Most Veteran referrals conform to the VISN catchment areas. To accommodate functional and geographic needs, individual Veterans may be referred to programs outside the local VISN areas. Advanced low-vision clinics and outpatient blind rehabilitation clinics with hoptel or lodger programs are able to accommodate Veterans who live geographically distant.

b. The presence of complicating medical or mental conditions does not preclude Veterans or Servicemembers from participation in an outpatient clinical program. To maximize benefit from the program, specific conditions that may adversely affect patient involvement needs to be addressed before scheduling (e.g., acute medical conditions, trauma, recovery from debilitating medical conditions such as alcohol or drug abuse, amputation with planned prosthesis, need for hearing aid, etc.). Referral to a clinical program best equipped to address a particular problem may be decided in consultation with program staff. *NOTE: The BRS national program office may be consulted for information and support.*

c. The low-vision Clinic Administrator and VISOR Chief have the authority to determine acceptability of applicants, but may seek input from appropriate health care professionals (e.g., physician, psychologist, eye care practitioner, nurse, etc.) regarding conditions that may impact the Veteran's health, stamina, cognitive ability, and rehabilitation potential.

15. VETERAN APPLICATION PROCEDURE AND MANAGEMENT

The BRS Program Office with the VHA Office of Information have developed a National Blind Rehabilitation Database that monitors all aspects of BRS service delivery for visually-impaired Veterans and Servicemembers. All programs overseen by BRS are required to use this database to document blind and vision rehabilitation service delivery.

a. Upon receiving a complete application through the BRS database, the clinic must accept (if appropriate and complete), or cancel, the Veteran applicant for participation in the program within 20 workdays.

b. Each referral is added to the clinic's wait list, and the Veteran is informed. The contact must include an estimated wait time to attend the training, as well as any cost that may be incurred by the Veteran.

c. After a Veteran has been scheduled for the rehabilitation program, the clinic provides information regarding the scope of services and estimated duration of training to the Veteran. If the Veteran is to be lodged, the clinic also provides the Veteran with appropriate information concerning clothing, footwear, equipment, details of class participation at the clinic, and any pertinent local information. The Veteran and the clinic must mutually agree upon the reporting date and any travel arrangements if applicable.

d. The clinic must cancel the application of any patient who declines three dates for scheduling an appointment at the clinic. The patient must be advised to reapply through the referring source or directly to the clinic when ready to attend (if appropriate). If the Veteran was to be lodged, the clinic must notify the patient that a reapplication is necessary and provide a courtesy copy to the referring source.

e. Whenever a referral is withdrawn or cancelled, information must be entered in the “Comments” section of the database detailing the circumstances leading to the action.

f. See following Table 1 for definitions of database status terminology.

TABLE 1: Legend for Application (Referral) Status

Database entry	Definition
Pending	No action taken on application.
In Review	Awaiting acceptance
Accepted	The patient will receive care
Offered	First date of service offered
Scheduled	Actual care scheduled date
Completed	Care was completed
Cancelled	Referral was cancelled by clinic
Withdrawn	Patient withdrew from service

16. PROSTHETIC EQUIPMENT AND SENSORY AIDS

Prosthetic issuance is in accordance with:

- a. VA Handbook 1173.5 Aids for the Blind Rehabilitation Service.
- b. VA Handbook 1173.2 Furnishing Prosthetic Appliances and Services.
- c. Prosthetics Clinical Management Program (PCMP) documents pertaining to issuance of prosthetics and services for the visually impaired, including:
 - (1) VHA PCMP Clinical Practice Recommendations for Prescription of Closed Circuit Televisions (CCTVs) and Other Electronic Optical Enhancement Devices (EOEDs), July 2002.
 - (2) VHA PCMP Clinical Practice Recommendations for Audible Prescription Reading Devices, August 2004.

(3) VHA PCMP Clinical Practice Recommendations for the Prescription of Computers and Peripheral Devices to Blind and Visually Impaired Veterans, August 2004.

(4) VHA PCMP Clinical Practice Recommendations: Prescription and Provision of Optical Low vision Devices to Aid in Overcoming Visual Impairment, September 2004.

(5) VHA PCMP Clinical Practice Recommendations: Prescription and Provision of Daily Living and Mobility Devices for Legally Blind and Visually Impaired Veterans, September 2004.

d. Prosthetics and Sensory Aids Service Office, National Contract Guidelines specific to Sensori-Neuro Aids that includes Aids for the Blind and Visually Impaired, Optical Aids for the Blind, CCTV, etc.

e. VHA Handbook 1173.12, Prescription Optics and Low vision Devices.

17. DOCUMENTATION

a. The documentation of patient assessments, treatment plans, progress notes and discharge summaries must be consistent with VA requirements, as well as the requirements of the Joint Commission, and CARF. Workload data (e.g., encounter codes and Decision Support System (DSS) information) are entered into the electronic medical record using appropriate stop codes. Intermediate Low-Vision clinics are to use stop code 438; Advanced Low-Vision clinics must use stop code 437; VISOR clinics must use stop code 220. All BRS outpatient clinics that do not employ event capture mechanisms must use the BRS Electronic Encounter Form (EEF) to record patient treatment with definitions involving classification of diseases International Classification of Diseases -9th edition (ICD-9) and impairments codes, current procedural terminology (CPT) codes, and clinic workload designation. Those medical facilities that employ event capture mechanisms need to use appropriate ICD-9 and CPT codes contained in the BRS EEF.

b. The blind or vision rehabilitation clinical program compiles data from outcomes assessment that measures effectiveness, efficiency, patient satisfaction, and stakeholder satisfaction.

18. RESOURCE ALLOCATION

In order to ensure that outpatient clinics provide the highest-quality vision and blind rehabilitation and health care, the VA medical center housing the clinic is expected to continue providing the budget, space, equipment, and personnel deemed necessary.

a. Budget

(1) Budget levels vary and are modified when advances in the field of vision and blind rehabilitation, such as new technology and innovative programs, create a demand.

(2) Budget planning at the VA facility housing a blind or vision rehabilitation clinic must take into account the regional scope of the clinic within the VISN. A coordinated budgetary decision process requires input from the VISN, as well as the Director, BRS, VA Central Office.

b. **Space**

(1) Assigned clinical space must be sufficient to allow efficient and safe operation of the program, and to enable visually-impaired Veterans to maximize their rehabilitation potential.

(2) Clinical areas need to complement and enhance the rehabilitation process. Care needs to be taken to ensure that environmental lighting, color, contrast, signage, and tactile environment support the learning, safety, and wayfinding needs of patients who are visually impaired.

(3) Storage space needs to be sufficient to secure assessment and training equipment, any recreational equipment, and the prosthetic items needed by staff.

c. **Equipment.** Clinic staff must ensure that patients benefit from the adaptive equipment that best meets their needs. Staff must evaluate emerging technology to ensure that the most effective equipment is acquired and used for training and for issuance to patients.

d. **Personnel.** Outpatient vision and blind rehabilitation clinical programs in BRS are staffed by 601series Blind Rehabilitation Specialists who work with licensed, credentialed eye care practitioners (optometrists and ophthalmologists), other professionals in BRS, nurses, social workers, and other VHA health care and rehabilitation professionals to ensure that Veterans with visual impairment are provided state-of-the-art blind and vision rehabilitation. Blind Rehabilitation Specialists are Hybrid Title 38 professionals and must meet the qualification standard for their series and ranks.

19. PROFESSIONAL TRAINING

a. The clinical program develops core competencies for staff that include discipline-specific and program-specific competencies in accordance with CARF and Joint Commission guidelines.

b. Educational programs for professional staff must be provided within the framework of strategic planning, quality management, and performance improvement.

c. Staff members have the responsibility to pursue educational opportunities to attain and maintain required credentials in blind and vision rehabilitation and to stay abreast of new developments in the field.

20. EDUCATIONAL AFFILIATIONS WITH UNIVERSITY PROGRAMS.

a. In an effort to improve the quality of blind and vision rehabilitation services in VA, as well as the private sector, VA clinical programs establish educational affiliations with relevant university programs. Any contractual relationship with a university program must be developed within VA and medical center policies, and must be periodically reviewed for continued appropriateness and cost effectiveness.

b. Associated health trainee programs may include, but are not limited to: O&M, vision rehabilitation therapy, low-vision therapy, eye care, and eye care technicians and technologists.

21. REFERENCES

a. VHA Handbooks:

(1) VHA Handbook 1174.04, Blind Rehabilitation Center Program Procedures.

(2) VHA Handbook 1174.01, Blind Rehabilitation Outpatient Specialist Program Procedures.

(3) VHA Handbook 1174.02, Blind Rehabilitation Service National Program Consultant Procedures.

(4) VHA Handbook 1174.03, Visual Impairment Services Team Procedures.

(5) VHA Handbook 1172.1, Polytrauma Rehabilitation Procedures.

(6) VHA Handbook 1121.01, VHA Eye Care.

(7) VHA Handbook 1110.02, Social Work Professional Practice.

(8) VHA Handbook 1173.12, Prescription Optics and Low vision Devices.

(9) VA Handbook 1173.5, Aids for the Blind Rehabilitation Service.

(10) VA Handbook 1173.2, Furnishing Prosthetic Appliances and Services.

d. Rehabilitation Accreditation Commission (CARF), Comprehensive Blind Rehabilitation Services Standards Manual.

e. Joint Commission on Accreditation of Healthcare Organizations, Comprehensive Accreditation Manual for Hospitals.

f. Prosthetics Clinical Management Program (PCMP) documents:

(1) VHA PCMP Clinical Practice Recommendations for Prescription of Closed Circuit Televisions (CCTVs) and Other Electronic Optical Enhancement Devices (EOEDs), July 2002.

(2) VHA PCMP Clinical Practice Recommendations for Audible Prescription Reading Devices, August 2004.

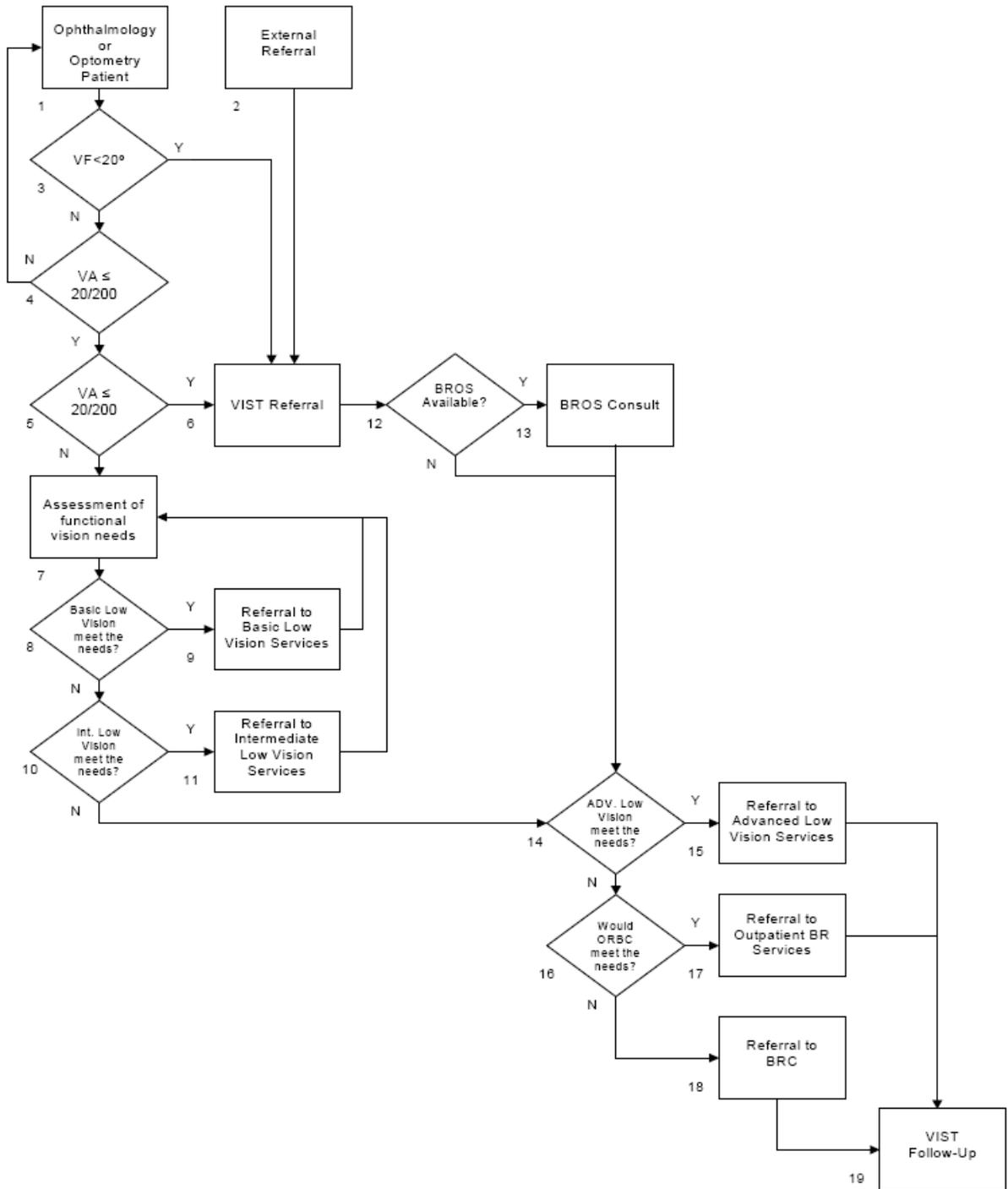
(3) VHA PCMP Clinical Practice Recommendations for the Prescription of Computers and Peripheral Devices to Blind and Visually Impaired Veterans, August 2004.

(4) VHA PCMP Clinical Practice Recommendations: Prescription and Provision of Optical Low vision Devices to Aid in Overcoming Visual Impairment, September 2004.

(5) VHA PCMP Clinical Practice Recommendations: Prescription and Provision of Daily Living and Mobility Devices for Legally Blind and Visually Impaired Veterans, September 2004.

g. Disability Evaluation under Social Security: 2.00 Special Senses and Speech. Blue Book 2006. View online at: <http://www.ssa.gov/disability/professionals/bluebook/2.00-SpecialSensesandSpeech-Adult.htm>

ALGORITHM FOR VISUALLY IMPAIRED VETERANS



ANNOTATIONS TO ALGORITHM FOR VISUALLY IMPAIRED VETERANS

This algorithm, developed by the Visual Impairment Advisory Board (VIAB), shows the process of referrals through the continuum of care for visually impaired Veterans.

1. Veterans with vision loss are identified primarily in eye care clinics.
2. “External referral” means referral by sources other than eye care, including primary care and other referral sources. Veterans with visual impairment may be referred to the Visual Impairment Services Team (VIST) Coordinator from providers (e.g., primary care), outside services (e.g., community or state) or by the Veterans themselves and their family members. The VIST coordinator assesses these referrals. If the level of visual impairment is in question, the VIST Coordinator refers the Veteran to the eye clinic for examination. If the documentation of visual impairment is adequate, referral to appropriate visual impairment services is made based on visual impairment and functional goals.
3. Visual field qualifying for legal blindness is less than 20 degrees centrally using the III4e isopter on the Goldmann kinetic perimetry test with appropriate near correction, or IV4e isopter if aphakic or not well adjusted to an intraocular lens implant or contact lens.
4. If a patient has better than 20/70 best corrected acuity in the better eye, the patient will exit the algorithm as they do not fit within the VIAB, definition of low vision (vision loss equal to or greater than 20/70 in the better seeing eye with correction) nor the Veterans Benefits Administration (VBA) definition of legal blindness (Disability reference guide). If a patient does not meet the VIAB definition of low vision, this does not limit the Veteran’s access to low vision care. Measurement of visual acuity should be performed as described for disability measurement and accurate International Classification of Diseases- 9th Edition (ICD-9) impairment coding.
5. Visual acuity is best corrected resolution in the better-seeing eye (not using eccentric fixation or eccentric viewing) as measured by the appropriate chart. Veterans who are legally blind or who have excess disability are referred to VIST for case management. Veterans who require VIST management may be referred by VIST to Blind Rehabilitation Outpatient Specialist (BROS) advanced outpatient low vision services, outpatient blind rehabilitation services, and inpatient blind rehabilitation services.
6. Low vision patients will be assessed for visual functional needs in order to best match the Veterans’ functional needs with the available low vision services.
7. Basic low vision services include optical devices (e.g., spectacle magnification and some magnification devices) and environmental adaptations (lighting and contrast).
8. Basic low vision services should be available in all Veterans Health Administration (VHA) eye clinics. Training in use of vision and low vision devices is limited.

9. Intermediate low vision services provide a larger array of optical devices. In addition, there is more training in use of vision and of the low vision devices as well as limited training in Activities of Daily Living (ADL).
10. Intermediate low vision services should be provided within the Veterans Integrated Service Network (VISN).
11. BROS are not available at all facilities. The VIST Coordinator must consult an available BROS to determine which component of the continuum of care would best meet the needs of the Veteran. The program that best fits the functional and social needs of the Veteran should be recommended.
12. BROS treatment is outlined in the BROS Handbook (1174.1).
13. Advanced low-vision services provide the full spectrum of optical devices, including electronic optical enhancement devices.
14. Advanced low vision services are provided in at least one site within each VISN.
15. Advanced low vision services are provided for veterans who are local, as well as for veterans who are geographically distant via lodger or hoptel programs.
16. Advanced outpatient blind rehabilitation services (also known as Visual Impairment Services Outpatient Rehabilitation (VISOR)) provide a broad spectrum of vision and blind rehabilitation.
17. VISOR programs were placed in VISNs where there is no inpatient blind rehabilitation center.
18. Inpatient blind rehabilitation centers (BRCs) offer the full spectrum of vision and blindness rehabilitation, social, nursing, psychological and medical services.
19. Patients who have attended outpatient and inpatient BRCs and are Operation Enduring Freedom, Operation Iraqi Freedom, or Operation New Dawn (OND) Veterans and Servicemembers with vision loss will likely be on VIST caseloads due to either legal blindness or excess disability, and will be offered lifetime case management.

CONTINUUM OF CARE TABLE

Continuum of Care

	Optical Devices	LVT/ Visual Skills	ADL/ Comm.	O&M	Adjust	Audiology	Manual Skills	General Medical	CAT
Basic	+	+							
Intermediate	++	++	+						
Advanced	+++	+++	+	+	+	+			
Outpatient Blind Rehab	+++	+++	++	++	++	++			++
Inpatient Blind Rehab	+++	+++	+++	+++	+++	+++	+++	+++	+++

APPENDIX B key:

- + Basic services are offered only
- ++ Moderate breadth and complexity of services offered
- +++ Full spectrum of services offered

LVT: Low-vision Therapy
 ADL: Activities of Daily Living
 CAT: Computer Access Training
 Rehab: Rehabilitation

**DESCRIPTION OF SERVICES TO BE PROVIDED BY OUTPATIENT CLINICS IN
THE BLIND REHABILITATION SERVICE CONTINUUM OF CARE****OUTPATIENT INTERMEDIATE LOW VISION CLINIC**

1. CLINICAL LOW VISION EXAMINATION. In the Intermediate Low-vision Service, a moderate breadth and level of complexity of services are provided. The moderate spectrum of low vision devices available for prescribing include (but are not limited to) spectacle prescriptive considerations, such as height of bifocal segment, frame size and shape to allow use of the preferred retinal locus, tints for contrast and glare, specialized coatings, specialty contact lenses for low vision, spectacle microscopes, handheld and stand magnifiers, handheld and simple spectacle-mounted telescopes, absorptive lenses to control glare and photophobia, and to enhance vision, as well as other emerging technologies that may be evaluated and prescribed. An eye care practitioner who has been trained in vision rehabilitation must provide this service, or the trained eye care practitioner may directly supervise allied health professionals in some aspects of the clinical low-vision examination and the prescription of devices.

2. REHABILITATION ASSESSMENT AND INTERVENTION

a. Moderate level low vision therapy (LVT) is provided at this facility. LVT begins with a functional low vision evaluation that identifies visual impediments related to:

(1) Performance of activities of daily living (ADL) including dressing, personal health care and grooming, safe movement, care of orthotic, prosthetic and other health care devices;

(2) Performance of instrumental ADL including care of self and family, effective literacy and numeracy, health management, home management, meal preparation, safety awareness training, and shopping;

(3) Performance of educational pursuits including life-long learning;

(4) Performance of vocational pursuits including job, retirement, and volunteerism;

(5) Performance of leisure and social activities; and

(6) Community involvement.

b. Moderate level LVT uses functional-vision evaluation instruments to assess the use of vision for everyday tasks, such as reading (critical print size, rate, comprehension, endurance), writing (legibility, speed, endurance, spatial awareness), health-related skills (diabetic management; taking and organizing medications; care of medical, orthotic. and prosthetic devices; etc.), and other tasks that require the use of vision. Moderate level LVT provides an evaluation of work history, educational and vocational performance, use of technology, quality of life, and screens aspects of cognitive function, such as intelligence and cognition as they relate

to vision impairment, disability, and rehabilitation. The LVT may also include a depression screening for adequate referral.

c. Moderate level LVT provides training in the use of specific visual motor skills such as the identification and use of preferred retinal locus for fixation, accurate saccades, smooth pursuits, etc. Therapy is provided in the use of vision in both static and dynamic viewing conditions. Therapy is provided in the appropriate and safe use of low-vision devices, such as magnifiers, spectacle microscopes, telescopes, and other devices that include component skills, such as: establishing and maintaining focal distance; compensation for reduced field of view and/or depth of focus; development of necessary manual and ocular dexterity; as well as implementation of appropriate ergonomic strategies for effective and efficient positioning and management of fatigue. This can include the use of large print, reading stands, lamps and other illumination controls, writing implements, software, electronic devices, etc. Therapy is also provided in the use of appropriate environmental modifications, such as ergonomic positioning, organization, marking, etc., and in the use of environmental cues, such as signage, shadow, contrast, form, pattern, etc., for safe and effective management of the environment. Therapy is provided in efficient functioning to manage energy and to organize space and objects to enable goal achievement. Moderate LVT provides knowledge of local, regional, and national resources; it encourages consumerism.

d. Basic ADLs and communication intervention, provided at this clinic, includes an assessment of function and appropriate intervention for the impact of vision loss on instrumental ADLs related to preparing meals (“survival” cooking level, e.g., heating prepared food in microwave, making sandwiches, preparing beverages, using toaster oven and microwave, organization strategies in kitchen), managing money and paying bills, shopping for groceries or personal items, performing housework (light housekeeping and laundry), using a telephone, time management, grooming and health care (such as shaving, organizing and managing medications, managing diabetes, such as glucose monitoring, wound inspection, and bandaging, etc.). Communication activities include both receptive and expressive forms, written communication as writing legibly, financial management, accessing radio and television, hobbies, volunteer and leisure activities that are done in isolation, as well as in a social milieu.

**DESCRIPTION OF SERVICES TO BE PROVIDED BY OUTPATIENT CLINICS IN
THE BLIND REHABILITATION SERVICE CONTINUUM OF CARE****OUTPATIENT ADVANCED LOW VISION CLINIC**

1. CLINICAL LOW VISION EXAMINATION. An eye care practitioner who has been trained in vision rehabilitation will oversee the clinical low vision examination and prescribe optical and/or electronic devices, or the eye care practitioner may directly supervise allied health professionals in some aspects of the clinical low vision examination and prescription of devices. The full spectrum of low vision devices available for prescribing include, but are not limited to, spectacle (prescription (Rx) special considerations such as height of bifocal segment, frame size and shape to allow use of Preferred Retinal Locus (PRL), tints for contrast and glare, specialized coatings, specialty contact lenses for low vision, spectacle microscopes, handheld and stand magnifiers, handheld and spectacle mounted telescopes, bioptic-mounted telescopes, electronic aids (closed circuit television (CCTV), portable CCTV, head-mounted video magnifier, etc), absorptive lenses to control glare and photophobia and enhance vision as well as other emerging technologies that may be evaluated and prescribed.

2. REHABILITATION ASSESSMENT AND INTERVENTION

a. A low vision therapist (LVT) will provide rehabilitation assessment and intervention. This process begins with a functional low-vision evaluation that identifies visual impediments related to:

(1) Performance of developmentally appropriate activities of daily living (ADL) by the Veteran with low vision, including: dressing appropriately, personal health care and grooming, safe movement, and care of orthotic, prosthetic, and other health care devices;

(2) Performance of instrumental ADL, including: care of self and family, effective literacy and communication, health management, home management, meal preparation, safety awareness training, and shopping;

(3) Performance of educational pursuits including life-long learning;

(4) Performance of vocational pursuits including job, retirement, and volunteerism;

(5) Performance of leisure and social activities; and

(6) Community involvement.

b. Full spectrum LVT uses functional vision evaluation instruments to assess the use of vision for everyday tasks such as reading (critical print size, rate, comprehension, endurance), writing (legibility, speed, endurance, spatial awareness); health-related skills (diabetic management, taking and organizing medications, care of medical devices, etc.); and other tasks that require the use of vision. Full spectrum LVT provides an evaluation of work history,

educational and vocational performance, use of technology, quality of life, and aspects of cognitive function, such as intelligence and cognition as they relate to vision impairment, disability and rehabilitation.

c. Full spectrum LVT provides training in the use of specific visual motor skills, such as the identification and use of preferred retinal locus for fixation, accurate saccades, smooth pursuits, etc. Therapy is provided in the use of vision in both static and dynamic viewing conditions. Therapy is provided in the use of visual perceptual and visual motor skills in relation to overall perceptual and motor skills and coordination and the use of specific visual perceptual skills, such as visual closure, part-to-whole relationships, figure-ground, etc. Therapy is provided in the appropriate and safe use of low-vision devices, such as magnifiers, spectacle microscopes, CCTVs, mounted telelupes and telescopes, and other devices that includes component skills such as establishing and maintaining focal distance, compensation for reduced field of view and/or depth of focus, development of necessary manual and ocular dexterity, and implementation of appropriate ergonomic strategies for effective and efficient positioning and management of fatigue. Full spectrum LVT provides instruction in the use of adaptive equipment that enhance visual function and/or compensate for loss of vision through tactual and/or auditory means. This can include use of large print, reading stands, lamps and other illumination control, writing implements, software, electronic devices, etc. Therapy is also provided in the use of appropriate environmental modifications, such as positioning, organization, illumination control, marking, etc., and in the use of environmental cues, such as signage, shadow, contrast, form, pattern, and use of non-visual techniques for safe and effective management of the environment such as audio-output devices or tactile markings, etc. Therapy is provided in efficient functioning to manage energy and to organize space and objects to enable goal achievement. Full spectrum LVT provides knowledge of local, regional, and national resources; it encourages consumerism.

d. ADL and communication intervention includes an assessment of function and appropriate intervention for the impact of vision loss on instrumental ADL related to preparing meals, managing money and paying bills, shopping for groceries or personal items, housework, using a telephone, time management and grooming and health care (such as shaving, organizing and managing medications, managing diabetes, such as glucose monitoring, wound inspection, and bandaging, etc.). Communication activities include both receptive and expressive forms, written communication, such as writing legibly, accessing radio and television, hobbies, volunteer and leisure activities that are done in isolation, as well as a social milieu. ADL and communication includes assisting Veterans with understanding when using vision is not safe and/or effective, and includes introduction and training in other modalities, such as speech output and Braille.

e. An orientation and mobility (O&M) specialist provides basic O&M services. This includes a functional assessment of the O&M problems such as changing lighting conditions and glare, changes in terrain and depth, unwanted contacts, ability to judge distance and speed of cars and other important moving targets, identification of street signs and traffic signals, crosswalk lines, identification of the opposite corner of the street, and judging traffic patterns. Basic O&M includes assessment of critical incidents, such as bumps, stumbles and falls, the environment the Veteran moves in, and the development of a functional O&M plan. O&M therapy is provided in the use of optical and non-optical devices and interventions for distance tasks, such as field-enhancement devices, bioptic telescopes, absorptive lenses, etc., sighted guide technique and

basic safety techniques, orientation to the environment, use of maps, and use of the long cane for obstacle detection. The long cane, when used appropriately to detect drop-offs, curbs, terrain changes, etc., frees the Veteran's use of vision for viewing ahead and also provides identification of the Veteran as visually impaired. Training in the use of the long cane, such as the diagonal technique or verification technique is often required. Basic O&M includes teaming with audiology for Veterans with hearing loss to ensure that Veterans are able to use auditory devices and auditory skills (especially the detection and localization of traffic sounds) to facilitate orientation and safe travel.

f. Every vision-impaired Veteran must be questioned regarding hearing loss. If a positive response is elicited, the Veteran undergoes audiological evaluation to determine the extent of the hearing loss and whether amplification would be of benefit. If necessary, amplification devices (hearing aids, cochlear implants, bone-anchored hearing aids, or assistive listening devices) are evaluated and dispensed, the Veteran must be trained in their use, care and maintenance through the audiology and speech pathology departments, and sufficient time must be allowed to ensure Veterans are properly acclimatized to amplification before participation in a blind or low-vision program. **NOTE:** *Service agreements between the low vision service and audiology service are recommended.*

g. Falls for older Veterans often have devastating consequences. Older Veterans are at higher risk for falling due to vision problems related to contrast sensitivity loss, loss of stereopsis, loss of acuity and loss of visual field. Falls risk is exacerbated by co-morbidities or medications that affect balance; they contribute to further destabilization. **NOTE:** *Service agreements between the low-vision service and the Physical Medicine and Rehabilitation department are recommended.*

h. Veterans with visual impairment have specific medical issues, such as managing medications and their compliance, wound care, diabetic care, environmental safety, and the effect of medications on falling and balance. **NOTE:** *Due to the potentially devastating effects of these issues, a service agreement between the low vision clinic and the Associate Director for Patient Care Services (Nursing Services) is recommended.*

i. All low-vision team members assist the Veteran and family in adjustment to changing vision and the life changes that accompany this process. Adjustment counseling, such as bridge counseling, family counseling, and/or supportive group counseling and discussion when required need to be offered. The VIST Coordinator, low vision eye care practitioner and therapists, who are educated in the psycho-social dynamics of low vision and blindness, must integrate appropriate adjustment strategies into their examination and therapeutic approaches; they support counseling, if the Veteran is referred to counseling professionals.

**DESCRIPTION OF SERVICES TO BE PROVIDED BY OUTPATIENT CLINICS IN
THE BLIND REHABILITATION SERVICE CONTINUUM OF CARE****VISUAL IMPAIRMENT SERVICES OUTPATIENT REHABILITATION (VISOR)
CLINIC**

1. SUPERVISORY LEADERSHIP. A full-time Supervisory Chief oversees this intensive rehabilitation program. The service chief will be a 601 series General Schedule (GS)-13 Blind Rehabilitation Specialist with a background in blind or vision rehabilitation practice as well as administrative experience. Patients may receive local intermittent services to achieve their goals or may be provided day-long regimens for 1 week or more through the lodger or hoptel program, and are followed for a period of time in their homes to ensure good transition of independent function and coping skills.

2. CLINICAL LOW VISION EXAMINATION. In the Outpatient Hoptel Blind Rehabilitation Program, a full spectrum of low-vision devices available for prescribing include, but are not limited to, spectacle prescription (Rx) special considerations such as height of bifocal segment, frame size and shape to allow use of Preferred Retinal Locus (PRL), tints for contrast and glare, specialized coatings, etc., specialty contact lenses for low vision, spectacle microscopes, handheld and stand magnifiers, handheld and spectacle mounted telescopes, bioptic-mounted telescopes, electronic aids (closed circuit television (CCTV), portable CCTV, head-mounted video magnifier, etc), absorptive lenses to control glare and photophobia and enhance vision, as well as other emerging technologies that may be evaluated and prescribed. An eye care practitioner (Doctor of Medicine (MD) or Doctor of Osteopathy (DO)) who has been trained in vision rehabilitation provides this service, or the trained eye care practitioner may directly supervise allied health professionals in some aspects of the clinical low-vision examination and the prescription of such devices.

3. REHABILITATION ASSESSMENT AND INTERVENTION

a. Full spectrum low vision therapy (LVT) is recommended at this facility. Low vision therapy begins with a functional low vision evaluation that identifies visual impediments related to:

(1) Performance of developmentally appropriate activities of daily living by the Veteran with low vision including dressing appropriately, personal health care and grooming, safe movement, care of orthotic, prosthetic and other health care devices;

(2) Performance of instrumental activities of daily living by the person with low vision including care of self and family, effective literacy and communication, health management, home management, meal preparation, safety awareness training, and shopping;

(3) Performance of educational pursuits including life-long learning;

- (4) Performance of vocational pursuits including job, retirement and volunteerism;
- (5) Performance of leisure and social activities; and
- (6) Community involvement.

b. Full spectrum LVT uses functional vision evaluation instruments to assess the use of vision for everyday tasks such as reading (critical print size, rate, comprehension, endurance), writing (legibility, speed, endurance, spatial awareness), health-related skills (taking and organizing medications, care of medical devices, etc.) and other tasks that require the use of vision. Full spectrum LVT provides an evaluation of work history, educational and vocational performance, use of technology, quality of life, and aspects of cognitive function, such as intelligence and cognition as they relate to vision impairment, disability, and rehabilitation.

c. Full spectrum LVT provides training in the use of specific visual motor skills, such as the identification and use of preferred retinal locus for fixation, accurate saccades, smooth pursuits, etc. Therapy is provided in the use of vision in both static and dynamic viewing conditions. Therapy is provided in the use of visual perceptual and visual motor skills in relation to overall perceptual and motor skills and coordination and the use of specific visual perceptual skills, such as visual closure, part-to-whole relationships, figure-ground, etc. Therapy is provided in the appropriate and safe use of low-vision devices, such as magnifiers, spectacle microscopes, CCTVs, mounted telelupes and telescopes, and other devices that include component skills, such as: establishing and maintaining focal distance; compensation for reduced field of view and/or depth of focus; development of necessary manual and ocular dexterity; and implementation of appropriate ergonomic strategies for effective and efficient positioning and management of fatigue. Full spectrum LVT provides instruction in the use of adaptive equipment that enhance visual function and/or compensate for loss of vision through tactual and/or auditory means. This can include use of large print, reading stands, lamps and other illumination control, writing implements, software, electronic devices, etc. Therapy is also provided in the use of appropriate environmental modifications (e.g., positioning, organization, marking), and in the use of environmental cues (e.g., signage, shadow, contrast, form, pattern), and use of non-visual techniques for safe and effective management of the environment, such as audio or tactile markings, etc. Therapy is provided in efficient functioning to manage energy and to organize space and objects to enable goal achievement. Full spectrum LVT provides knowledge of local, regional, and national resources; it encourages consumerism. Two low-vision therapists are provided in the resource budget for these services.

d. A moderate level of activities of daily living (ADL) and communication training (is recommended at this facility. ADL and communication training intervention includes an assessment of function and appropriate intervention for the impact of vision loss on instrumental ADL related to: preparing meals, managing money and paying bills, shopping for groceries or personal items (teaming with orientation and mobility (O&M) Specialist), performing housework, using a telephone, time management, and grooming and health care (such as shaving, organizing and managing medications, and managing diabetes as glucose monitoring, wound inspection, and bandaging, etc.). Communication activities include both receptive and expressive forms. This includes written communication (e.g., writing legibly using visual and/or

non-visual techniques), accessing radio and television, hobbies, volunteer and leisure activities that are done in isolation, as well as a social milieu. ADL and communication training include assisting Veterans with understanding when using vision is not safe and/or effective, and includes introduction and training in other modalities, such as speech-output and Braille when needed.

e. A moderate level of O&M training is recommended at this facility. Moderate level O&M includes a functional assessment of the O&M problems, such as: changing lighting conditions and glare; changes in terrain and depth; unwanted contacts; ability to judge distance and speed of cars and other important moving targets; identification of street signs, traffic signals, and crosswalk lines; identification of the opposite corner of the street; and judging traffic patterns. Moderate level O&M includes an assessment of critical incidents, the environment the Veteran moves in, and the development of a functional O&M plan. O&M therapy is provided in the use of optical and non-optical devices and interventions for distance tasks. This includes: field enhancement devices, bioptic telescopes, absorptive lenses, etc., sighted guide technique and basic safety techniques, orientation to the environment, use of maps, and use of the long cane to enhance the use of vision. The long cane, when used appropriately to detect drop-offs, curbs, terrain changes, etc., frees the Veteran's use of vision for viewing ahead and provides identification of the Veteran as being visually impaired. Long cane techniques must be taught to Veterans whose vision is not useful for traveling. Training in the use of the long cane, such as diagonal technique or verification technique is often required. Moderate level O&M includes teaming with audiology for Veterans with hearing loss to ensure Veterans are able to use auditory devices and auditory skills (especially the detection and localization of traffic sounds) to facilitate orientation and safe travel.

f. Every vision-impaired Veteran must be questioned regarding hearing loss. If a positive response is elicited, the Veteran undergoes audiological evaluation to determine the extent of the hearing loss and whether amplification would be of benefit. If necessary, assistive listening devices are evaluated and dispensed, and the Veteran is trained in their use, care, and maintenance. Vision Rehabilitation staff work closely with audiology and speech pathology staff to ensure that Veterans gain maximum audiological input and that audiology and blind rehabilitation staff work as an interdisciplinary team. A service agreement needs to be developed between the Outpatient Blind Rehabilitation Service and the Audiology Service to ensure that timely patient appointments are available so that Veterans who require audiological services may be served while in the Blind Rehabilitation Program.

g. Falls often have devastating consequences for older Veterans, who are particularly at higher risk of falling due to vision problems related to contrast-sensitivity loss, loss of stereopsis, loss of acuity, and loss of visual field. Falls risk is exacerbated by co-morbidities and/or medications that affect balance and can further contribute to destabilization. A service agreement needs to be developed between the Outpatient Blind Rehabilitation Service and Physical Medicine and Rehabilitation Service (PM&RS) to ensure that timely patient appointments are available. Veterans who require intervention for falls and balance problems may then be assessed and a rehabilitation plan developed with the PM&RS while the Veteran is in the Blind Rehabilitation Program.

h. Veterans with visual impairment have specific medical issues, such as managing medications and their compliance, wound care, diabetic care, environmental safety and effect of medications on falling and balance. ***NOTE:** Due to the potentially devastating effects of these issues, a service agreement between the low-vision clinic and the Associate Director for Patient Care Services (Nursing Services) is recommended.*

i. All low vision team members assist the Veteran and family in adjustment to changing vision and the life changes that accompany this process. Adjustment counseling, such as bridge counseling, family counseling, and/or supportive group counseling, and discussion need to be offered. The VIST Coordinator, low vision eye care practitioner and therapists, who are educated in the psycho-social dynamics of low vision and blindness, must integrate appropriate adjustment strategies into their examination and therapeutic approaches; they support counseling, if the Veteran is referred to counseling professionals.

j. Computer access training is provided for visually-impaired Veterans who wish to use the computer for internet, email access, and word processing, as well as any other activities that are avocational or pre-vocational in nature.

DEPARTMENT OF VETERANS AFFAIRS (VA) BLIND REHABILITATION SERVICE
OUTPATIENT CLINIC LOCATIONS

OUTPATIENT INTERMEDIATE LOW VISION CLINICS

VISN	FACILITY
1	White River Junction VA Medical Center, White River Junction, VT
2	Samuel S. Stratton VA Medical Center, Albany NY
3	Franklin Delano Roosevelt Campus, Montrose, NY
4	VA Pittsburgh Healthcare System (HCS), Pittsburgh, PA
5	Martinsburg VA Medical Center, Martinsburg, WV
6	Hampton VA Medical Center, Hampton, VA
7	William Jennings Bryan Dorn VA Medical Center, Columbia, SC
8	Ocala Community-based Outpatient Clinic (CBOC), Ocala, FL
9	Memphis VA Medical Center, Memphis, TN
10	Cincinnati VA Medical Center, Cincinnati, OH
11	John D. Dingell VA Medical Center, Detroit, MI
12	William S. Middleton Mem. Veterans Hospital, Madison, WI
15	St. Louis VA Medical Center, St. Louis, MO
16	Oklahoma City VA Medical Center, Oklahoma, OK
17	Central Texas Veterans HCS, Temple, TX
18	New Mexico VA HCS, Albuquerque, NM
19	VA Montana HCS, Fort Harrison, MT
20	Spokane VA Medical Center, Spokane, WA
21	VA Ukiah CBOC, Ukiah, CA
22	VA Loma Linda HCS, Loma Linda, CA
22	VA Southern Nevada HCS, Las Vegas, NV
23	Sioux Falls VA Medical Center, Sioux Fall, SD

DEPARTMENT OF VETERANS AFFAIRS (VA) BLIND REHABILITATION SERVICE
OUTPATIENT CLINIC LOCATIONS

OUTPATIENT ADVANCED LOW VISION CLINICS

VISN	FACILITY
1	VA Boston Healthcare System (HCS), Jamaica Plains, Jamaica, MA
2	Syracuse VA Medical Center, Syracuse, NY
3	Brooklyn Campus, NYHHCS, Brooklyn, NY
4	Philadelphia VA Medical Center, Philadelphia, PA
5	Baltimore VA Medical Center, VA Maryland HCS, Baltimore, MD
6	Salisbury W.G. Bill Hefner VA Medical Center, Salisbury, NC
7	Atlanta VA Medical Center, Decatur, GA
8	James Haley Veterans Hospital, Tampa, FL
9	Tennessee Valley HCS, Nashville, TN
10	Dayton VA Medical Center, Dayton, OH
11	Aleda E. Lutz VA Medical Center, Saginaw, MI
12	Clement J. Zablocki VA Medical Center, Milwaukee, WI
15	Robert J. Dole VA Medical Center, Wichita, KS
16	Central Arkansas Veterans HCS, Little Rock, AR
17	VA North Texas HCS, Dallas, TX
18	Carl T. Hayden VA Medical Center, Phoenix, AZ
19	VA Salt Lake City HCS, Salt Lake City, UT
20	Portland VA Medical Center, Portland, OR
21	Martinez Outpatient Clinic, Martinez, CA
22	VA Greater Los Angeles HCS, Los Angeles, CA
22	VA San Diego HCS, San Diego, CA
23	VA Central Iowa, Des Moines, IA

DEPARTMENT OF VETERANS AFFAIRS (VA) BLIND REHABILITATION SERVICE
OUTPATIENT CLINIC LOCATIONS

VISUAL IMPAIRMENT SERVICES OUTPATIENT REHABILITATION (VISOR)
CLINICS

VISN

FACILITY

- | | |
|----|--|
| 2 | VA Western Healthcare System (HCS), Buffalo, NY |
| 3 | East Orange Campus of New Jersey HCS, East Orange NJ |
| 4 | Lebanon VA Medical Center, Lebanon, PA |
| 5 | Washington, DC. VA Medical Center, Washington, DC |
| 6 | Hunter Holmes McGuire, VA Medical Center, Richmond, VA |
| 9 | Lexington VA Medical Center, Lexington, KY |
| 10 | Louis Stokes VA Medical Center, Cleveland, OH |
| 11 | Battle Creek VA Medical Center, Battle Creek, Michigan |
| 15 | Kansas City VA Medical Center, Kansas City, MO |
| 16 | Michael E. DeBakey VA Medical Center, Houston, TX |
| 19 | VA Eastern Colorado HCS, Denver, CO |
| 23 | Minneapolis VA Medical Center, Minneapolis, MN |

**VHA EXECUTIVE DECISION MEMORANDUM
CONTINUUM OF CARE FOR VISUALLY IMPAIRED VETERANS**

**VHA EXECUTIVE DECISION MEMO
CONTINUUM OF CARE FOR VISUALLY IMPAIRED VETERANS**

DATE:

TO: Acting Under Secretary for Health (10)

FROM: Chief Patient Care Services Officer (11) *WJH*

THRU: Acting Principal Deputy Under Secretary for Health (10A)

SUBJECT: Continuum of Care for Visually Impaired Veterans

For Further Information Contact: Lucille B. Beck, Ph.D, Chief Consultant, Rehabilitation Services (117)

Action Requested: Request for approval
 Request for discussion or further review
 For Your Information
 Other

STATEMENT OF ISSUE:

Due to the increasing age of our veteran population and the known prevalence of age-related visual impairment, the Visual Impairment Advisory Board (VIAB) undertook an evaluation of the prevalence and distribution of visual impairment, including legal blindness, in the veteran population. That data disclosed an increasing age-related incidence of visual impairment that is not geographically uniform across the country. We subsequently compared the current capacity to provide care to this population with this epidemiological data. Based on that assessment we recommend that VHA begin to improve the continuum of services to this population by setting aside the resources necessary to build this infrastructure.

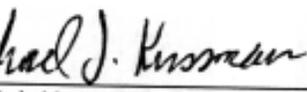
RECOMMENDATION (Option 4):

VHA should set aside resources to fund the start-up costs (\$14,689,650 in fiscal year 2007) and two subsequent years of recurring costs (\$12,449,515 per year in fiscal years 2008 and 2009) for establishing a continuum of care for visually impaired veterans. These funds would be allocated to Networks after they submit an approved plan based on the gap analysis done by the Visual Impairment Advisory Board (VIAB). Each Veterans Integrated Network (VISN) will develop a plan to provide the full range of low vision and blind rehabilitation services from basic low vision care through

inpatient blind rehabilitation. Services can be provided through a combination of "in-house" services, sharing between Networks, and contracts with community services. It is expected that inpatient blind rehabilitation will be provided through sharing agreements with other Networks. All visually impaired veterans, including those with chronic diseases, will have access to appropriate vision rehabilitation services.


Madhu Agarwal, MD, MPH

Concur/ NonConcur:  Date: 8/20/06
Gerald M. Cross, MD, FAAP
Acting Principal Deputy Under Secretary for Health

Approve/ Disapprove:  Date: 10/20/06
Michael J. Kussman, MD, MS, MACP
Acting Under Secretary for Health

I. STATEMENT OF ISSUE RELATED TO EXECUTIVE DECISION MEMO:

Eligibility for blind rehabilitation centers has expanded over the years to include all legally blind veterans regardless of whether their blindness is related to military service. With the aging of the veteran population, the prevalence of visual impairment and blindness associated with aging increases dramatically. Consequently the demand for low vision and blind rehabilitation services has grown significantly. This dramatic increased demand has compromised timely access to residential blind rehab therapy.

This older visually impaired and blind veteran population differs strikingly from the young war blinded veterans for which the system was originally designed. Typically, these veterans are more elderly often with multiple co-morbid conditions that require monitoring and management during the rehabilitation process. Age-related vision loss is typically progressive, but rarely total. These veterans may have residual vision that frequently can be enhanced with optical low vision devices and less intensive training. Visual rehabilitation should be provided along a continuum as vision loss progresses.

Some visually impaired veterans are reluctant to leave home to attend a residential, Blind Rehabilitation Center (BRC). Unfortunately, VA has little capacity to provide essential services to this population on an outpatient basis. Clearly, there is an enormous need for alternative models of outpatient service delivery. While some VA facilities have implemented such models with good success, short-term outpatient programs, which could meet many of this populations' needs, are generally not widespread. The full array of services provided in these models should be made available across all Networks within the VA healthcare system. To the extent that quality services exist in the local community, VA should utilize these services when appropriate for those veterans either unable or unwilling to attend a comprehensive residential BRC. To that end, the Visual Impairment Advisory Board has developed recommendations to develop a continuum of rehabilitative services that augments the services already in place.

The World Health Organization (WHO) developed a uniform classification system that has been incorporated into the International Classification of Diseases and is accepted as the international classification standard. The following table (Table 1) provides the WHO classifications:

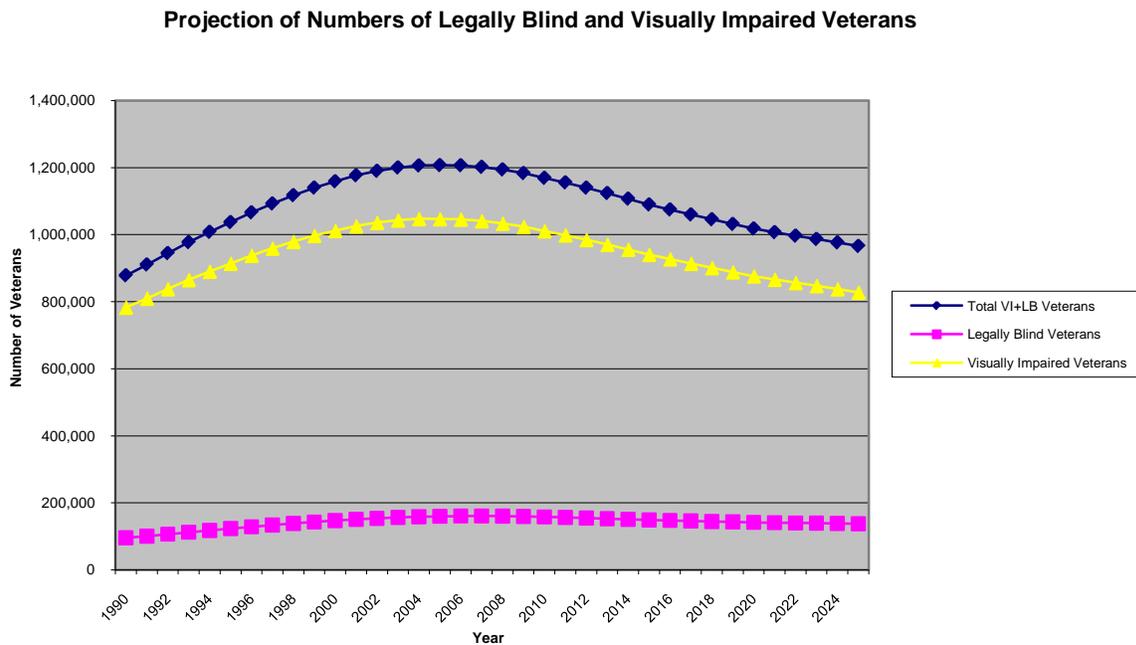
Table 1

CATEGORY	GRADE	CRITERIA
Normal Vision	0	20/25 or better
Near-Normal Vision	0	20/30-20/60
Low Vision Moderate	1	20/70-20/160
Visual Impairment Severe	2	20/200-20/400
Blindness Profound	3	20/500 to 20/1000 or VF<5°
Visual Impairment Near Total	4	<20/1000 or VF<5°
Total Visual Impairment	5	No Light Perception (NLP)

VHA should develop a continuum of tailored services that provides accessible comprehensive rehabilitative care for patients throughout this continuum of visual impairment.

Veteran projections prepared for Capitol Asset Realignment for Enhanced Services (CARES) (Delaune, 2002 CARES Summary Legally Blind - FY 1990-2025) indicate that the population of legally blind veterans, currently 157,000, will peak at 161,000 in 2007, and will decline to only 138,000 by 2025. The number of low vision veterans; those having significant, uncorrectable visual impairment between 20/70 to, but not including, legal blindness, is currently estimated to be 1,026,000. This population peaked at 1,048,000 in 2004, and will decline to 828,000 in 2025 (Figure 1).

Figure 1



The co-existence of visual disabilities with other disabilities affecting the same aging individual is common. These impairments and disabilities result from a complex interaction among medical conditions, related morbidity, and the environmental factors that affect the veteran and his/her caregivers. Rehabilitation services designed to address the complex nature of these impairments and disabilities must be interdisciplinary. Their development requires the creative energy of multiple disciplines working in a synergistic manner. For example, rehabilitative interventions such as magnifiers that target poor visual acuity may improve visual performance. However, everyday function may not be enhanced if appropriate environmental or assistive technologies are not available to complement the visual performance improvements.

Similarly, improved visual function may not improve overall everyday function and quality of life if those same veterans also have medical conditions that affect their ability to function. Thus, an interdisciplinary approach to developing optimal rehabilitative interventions for this population is critical. Such interventions might include assistive technologies, environmental modifications, training programs, and various combinations

of these strategies. The comprehensive vision rehabilitation services being developed by the VA are a model for a national vision/blind rehabilitation plan.

II. SUMMARY OF FACTS / BACKGROUND RELATED TO EDM:

Each VISN will be required to develop and implement a plan for the provision of eye care to veterans with visual impairment ranging from 20/70 to total blindness. The continuum of care will range from basic low vision to inpatient blind rehabilitation centers. The plans will have the following components:

1. The Visual Impairment Services Team (VIST) Coordinator, Blind Rehabilitation Outpatient Specialist (BROS), or eye care professional (optometrist or ophthalmologist), will assess all blind and visually impaired veterans in order to match them with the program that will best meet their functional needs. The VIST coordinator will function as the case manager for identified legally blind veterans.
2. Basic low vision care should be available at all sites with eye clinics; however, more advanced levels of care including blind rehabilitation centers can be centralized, contracted, or shared between VISNs.
3. Blind and visually impaired veterans will have timely access to services.
4. Functional outcomes and access to services will be measured as part of the VISN Directors performance.
5. Staffing levels will reflect the increased workload.
6. VISNs will submit initial plans based on the Gap Analysis conducted by the VIAB and should be required to develop a plan that stays within the total resources identified in that assessment. Plans should be approved by the Blind Rehabilitation Program Office, Rehabilitation Strategic Healthcare Group.

Although Networks should be allowed to creatively craft this continuum, the following tables outline the types of services and providers the VIAB identified as necessary to develop a continuum of care. Networks will need to assure that veterans with low visual acuity will be assessed for their visual functional needs and that these needs can be met through appropriate rehabilitation and training, including optical aid usage, visual skills training, activities of daily living (ADL) enhancement, orientation and mobility (O&M) training, adjustment to vision loss counseling, audiology services, manual skills training, medical management of co-morbid diseases and computer access training (CAT). The veteran should be referred to a low vision or legally blind program that best matches their functional needs (Table 2). Trained, competent providers are required to deliver these services (Table 3). This process is summarized in the Algorithm for Visually Impaired Veterans (Figure 2). We view these as minimum specifications that should guide Network planning.

Table 2
Continuum of Care

	Optical Devices	LVT/ Visual Skills	ADL/ Comm.	O&M	Adjust	Audiology	Manual Skills	General Medical	CAT
Basic	+	+							
Intermediate	++	++	+						
Adv Amb	+++	+++	+	+	+	+			
Adv Hoptel	+++	+++	+++	++	++	++			++
Inpatient Blind Rehab	+++	+++	+++	+++	+++	+++	+++	+++	+++

Table 2 key:

- + Basic services are offered only
- ++ Moderate breadth and complexity of services offered
- +++ Full spectrum of services offered

Table 3

Low Vision/Blind Providers

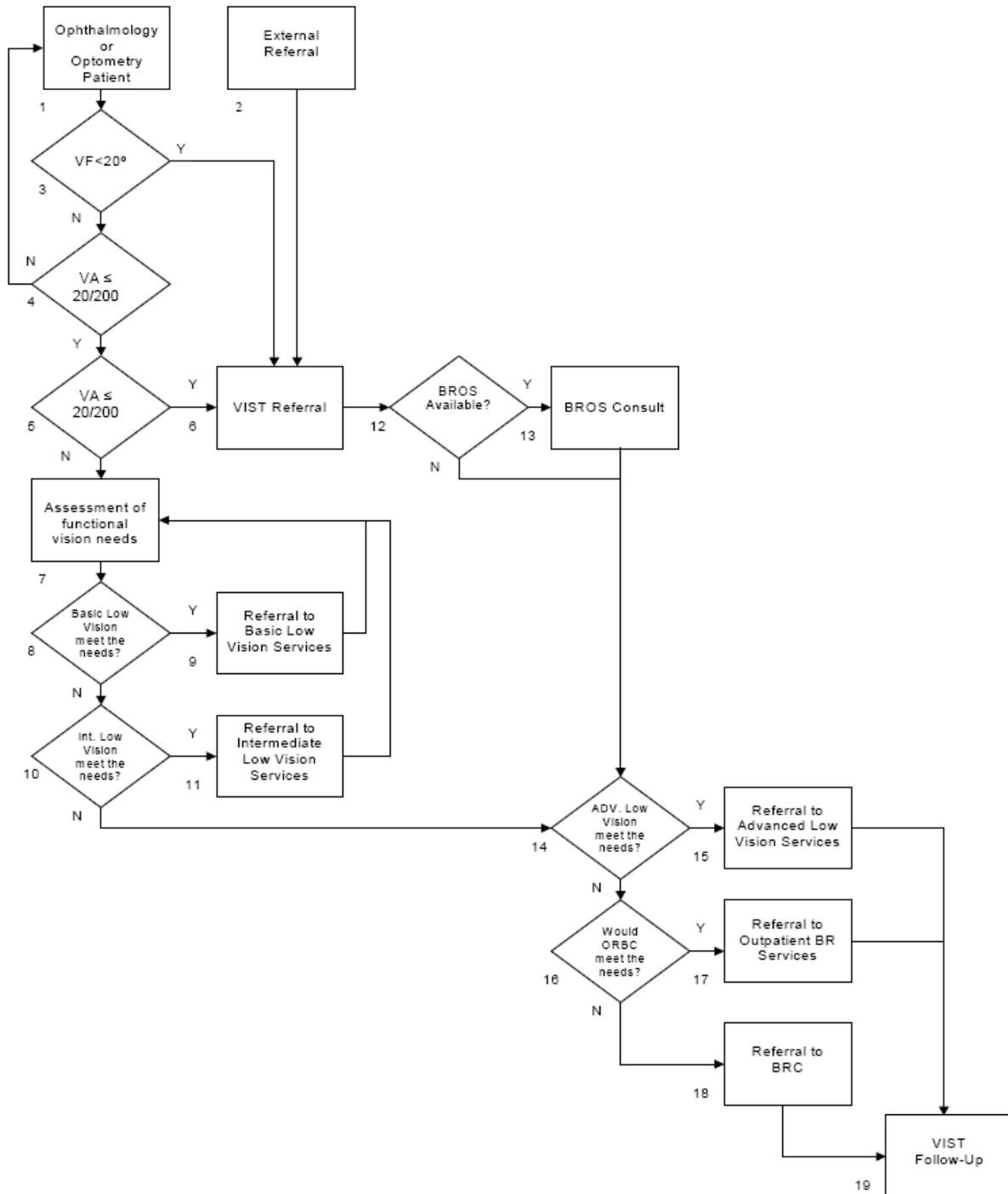
	Optical Devices	LVT/ Visual Skills	O&M	Adjust	Audiology	ADL/ Comm	Manual Skills	CAT	Pre/Post F/U
CAT Instr.								+	
O&M Specialist			+						
Low Vision Therapist	+/-	+				+/-			
Rehab Teacher						+	+		
Social W. Psychol.				+					
Ophthalmologist (MD)	+	+/-							
Audiologist					+				
BROS		+	+	+/-		+	+/-	+/-	+
VIST Coord.		+/-	+/-	+/-		+/-			+
Optometrist (OD)	+	+/-							

Table 3 key:

- + Provision of the specific service is a core component of training and competency of the provider.
- +/- The specific service is occasionally provided if provider is appropriately trained and competent.
- The provider rarely provides the specific service.

Figure 2

Algorithm for Visually Impaired Veterans



III. SYNOPSIS OF SIGNIFICANT RELATED ISSUES:

The Department of Veterans Affairs (VA) assumed the responsibility for the care and rehabilitation of war-blinded veterans in the mid-forties. VA activated its first comprehensive residential BRC in 1948. Over the years, the number of BRCs has expanded to ten across the country and Puerto Rico. The residential BRCs were designed to address the unique needs of young and suddenly, traumatically blinded servicemen and women returning from WWII. The focus was to establish a therapeutic environment in which these newly blinded individuals could develop healthy and wholesome attitudes about blindness. A place apart, where they could learn to accept and adjust to vision loss and acquire the necessary adaptive skills to overcome the handicap of blindness.

This approach embraced total immersion of the veteran (24/7) in this therapeutic environment for an extended period of time. The length of stay in training was determined by the individual veteran's needs (both medical and psycho-social), progress in developing proficiency with adaptive skills, and satisfactory adjustment. The VA designed a pre-vocational training model of service delivery to this population. Unquestionably, this model has proven highly successful at restoring visually impaired and blinded veterans' self-confidence, esteem, worth, and functional independence.

As VA gained experience providing services to the visually impaired and blinded veteran population, it became evident that blindness is an extremely isolating disability. Many blinded veterans were not taking advantage of all the benefits and services for which they were eligible. To address this need an aggressive outreach program was initiated in 1967. The Visual Impairment Services Team (VIST) approach was developed. VIST is an interdisciplinary team organized to assure the delivery of comprehensive services to legally blind veterans. The key professional on the team is the VIST Coordinator. The coordinator has the responsibility to coordinate the delivery of essential services, and serve as the case manager for all the blinded veterans in their facility's catchment area.

In the late 1970s, VHA recognized that there were a growing number of veterans who were not yet legally blind that needed rehabilitation services. The Directors of Blind Rehabilitation, Social Work, Psychology, and Optometry Services developed the Visual Impairment Center to Optimize Remaining Sight (VICTORS) program to address this unmet need. The initial VICTORS program started in 1979 at the Kansas City VA Medical Center. Over the years, VICTORS services became available to legally blind and visually impaired veterans who had need for intensive low vision rehabilitation services and/or were unable to receive care at a BRC. Currently there are four VICTORS programs nationwide.

To maintain capacity and provide world-class care, the Blind Rehabilitation Gold Ribbon Panel, Commissioned by the Under Secretary for Health in 1999, identified

the need to “develop and implement a continuum of care model. The continuum should extend from the veteran’s home environment to the local VA care site and the regionally based inpatient training program.” The VIAB, a multi-disciplinary, field-based group established to implement the Gold Ribbon Panel recommendations, identified treatment of visual impairment and legal blindness as a critical need for the veteran population. The supply of low vision and blind rehabilitation services does not meet the current demand, as evidenced by:

- It is estimated that there are over 1 million visually impaired veterans over the age of 45 in the United States.
- As of June 30, 2006 there were 1,179 legally blind veterans waiting for inpatient blind rehabilitation centers.
- The CARES market plan recommended additional blind rehabilitation beds be placed in VISNs 16 and 22.
- The VIAB survey of low vision rehabilitation services, provided outside of BRCs, showed that only 22 percent of VHA facilities that responded offer more than a basic level of low vision rehabilitation care.
- There are significant geographic gaps in the availability of low vision and blind rehabilitation services.

Development of a continuum of care model encompassing alternative rehabilitative service delivery will build upon the existing infrastructure. This includes ten BRCs, 93 full-time VIST Coordinators, approximately 50 part-time personnel with VIST responsibilities as collateral duties, 30 BROS, and five National Program Consultants. In addition, there are a variety of low vision services and blind rehabilitation service delivery models within VHA, e.g., VICTORS and VISOR. Services are provided using a multi-disciplinary and/or interdisciplinary team approach. A survey of low vision services provided during FY 2000 disclosed minimal low vision services are offered at 56 percent of eye clinics and advanced services in only ten percent of eye clinics. Currently, the staffing patterns, space, and equipment availability of local outpatient low vision services is unknown.

IV. CRITERIA FOR DECISION-MAKING:

Decisions for services should be driven by five domains of care: quality, veteran satisfaction, access, cost, and education/research.

1. *Will intervention occur early enough in the course of the veteran’s disease process to ensure that he or she can remain functionally independent and fully participate in care for other chronic condition?* Early intervention has been shown to greatly assist in adjustment to sight loss issues. Providing services at the earliest point in the continuum

will maximize independence and substantially reduce dependence on the family, community and the VA. As veterans move through the continuum, functional needs may become greater and more intensive services may be needed. Patient safety issues, such as falls, burns, and medication errors can be mitigated through appropriate vision rehabilitation services.

2. Will care be more accessible and timely to patients who are visually impaired?

Providing a wider array of outpatient services across the continuum of visual impairment coupled with the ability for a veteran to move through the continuum of care based on individual needs (visual and psycho-social) will reduce wait times for rehabilitation services. Patients who are visually impaired often have greater difficulty commuting long distances for evaluation and rehabilitation.

3. Will the care be more cost-effective? Patients with visual impairment often cannot participate in their care or follow through with treatment plans for managing other chronic disease such as diabetes and hypertension. Costs for inpatient stays associated with secondary disability and disease can be reduced through early training of visually impaired and legally blind veterans; e.g., mobility training to reduce falls, self-medication training to avoid drug over-dose resulting in hospitalization, etc. The cost of blind rehabilitation training should be reduced as more outpatient services become available.

V. STAKEHOLDERS:

Major stakeholder involvement has been vital since the inception of the Visual Impairment Advisory Board. The VIAB is a multi-disciplinary body that is comprised of veterans, veteran service organization representatives, optometry, ophthalmology, blind rehabilitation specialists, audiology, prosthetics, research, network and facility managers, and representatives of academic affiliates.

VI. OPTIONS AND ARGUMENTS:

Option 1: Maintain current level of support for low vision and blind rehabilitation.

Arguments Pro: Maintains the status quo. This option retains the current inpatient Blind Rehab Center (BRC) delivery model combined with local low vision rehabilitation services, which vary considerably across the country. Networks can work on developing this continuum of coordinated services within their existing resources.

Arguments Con: The Gold Ribbon Panel recommended development of a continuum of care for low vision and legally blind veterans. The USH has philosophically supported the development of these services in testimony. Many legally blind veterans cannot attend inpatient BRC and have very poor and spotty access to blind rehabilitation care. A haphazard arrangement of services will continue to exist for veterans with low vision. Networks really have no incentive to address this issue.

Option 2: Provide startup and recurring cost support for a total of 3 years for Advanced care only. This would require a total of \$10,933,023 in the first year to fund the start up and \$9,406,195 in year 2 and 3. The allocation of these resources would be guided by the gap analysis completed by the VIAB and based on plans submitted by each network.

Arguments Pro: This option funds the most significant part of this initiative to improve access to care. Veterans will have advanced low vision services provided within each VISN. Referral mechanisms to these services can be better integrated into the primary care programs within each network. Patient travel, and the expenses associated with it, will be minimized. Access to services will be greatly improved.

Arguments Con: Networks would have to address Intermediate care needs within their existing resources. Without the Intermediate level of services, a patchwork of care will still exist for patients with visual impairment who are not legally blind. Early intervention, which has been shown to improve functional status, will remain problematic for this population of patients. A shortage of trained providers exists, so staffing such an expansion may be difficult. The amount of resources in future budget years is difficult to predict and this option requires a multi-year commitment to expand access to services.

Option 3: Provide startup funding only for both levels of care. This would require a \$14,689,650 investment in FY07 only. The allocation of these resources would be guided by the gap analysis completed by the VIAB and based on plans submitted by each network.

Arguments Pro: This option requires a commitment only in FY07 and makes an investment in the entire continuum. Networks will have some incentive to address access issues for visually impaired veterans in a way that is less fragmented. Access to low vision services and VISN-wide access to advanced low vision care and blind rehabilitation will be enhanced. Access to inpatient BRC will not be affected.

Argument Con: Networks and facilities will need to cover the costs of subsequent years to maintain this infrastructure, until such time as VERA allocations account for the changes in workload. Staffing low vision and outpatient training sites may be problematic, especially in rural areas, due to shortages of trained professionals. Consequently, it may take more than one fiscal year to build these programs. An ability to carry this money over may help facilities invest more wisely.

Option 4: Provide startup and recurring cost support for a total of 3 years for Intermediate and Advanced care. This option would require \$14,659,650 in FY 07 and \$12,449,515 in both FY08 and FY09. The allocation of these resources would be guided by the gap analysis completed by the VIAB and based on plans submitted by each network.

Arguments Pro: Services will be comprehensive as a full continuum of care is developed on a network basis for patients with impaired visual acuity. Networks will have an incentive to address access to care for this population until such time as workload changes are incorporated into VERA allocations.

Arguments Con: Requires a significant multi-year commitment to fund this expansion.

VII. RECOMMENDED OPTION:

Option 4 is the recommended option.

VIII. DISSENTING OPINION REGARDING RECOMMENDED OPTION:

None.

IX. EFFECT OF RECOMMENDED OPTION ON EXISTING PROGRAMS AND/OR FACILITIES:

The overarching effect of adding additional services for visually impaired veterans is to provide them with the right care, at the right time, in the right place. However, the need to provide a full continuum of care may not necessarily be accomplished within existing VA resources (FTEE and budget). The increased numbers of visually impaired veterans will have a direct impact on the workload of the VIST Coordinator, BROS, optometrist, ophthalmologist, and prosthetic personnel. It may be necessary to increase the number of FTEE, or develop contracts for services to be obtained in the community.

There will also be an increase in costs associated with issuance of prosthetic devices (optical low vision devices and aids for the blind). Of note, providing services to visually impaired veterans earlier in the continuum may reduce the number of more resource intensive services that would be required as the veteran's vision continues to deteriorate. Providing the visually impaired veteran with an array of services available as they progress through the continuum of sight loss can mitigate the functional and psychological effects of vision loss.

X. LEGAL OR LEGISLATIVE CONSIDERATIONS OF THE RECOMMENDED OPTIONS:

All the recommended options presented in this document are fully compliant with Federal Law and the United States Code of Federal Regulations. New legislative authority is not necessary for implementation of these recommended options.

PL 104-262 The Eligibility Reform Act 1996 requires the Department of Veterans Affairs to maintain its capacity to provide specialized rehabilitative services to disabled veterans. The continuum of care enhances VA's ability to maintain capacity by

providing greater access to high quality vision rehabilitation services in the right place at the right time.

PL 107-135 The Department of Veterans Affairs Healthcare Program Enhancement Act of 2001 reinforces the requirements with respect to capacity in PL 104-262 and extends VA's requirement to report annually to Congress on whether it is indeed maintaining its capacity to provide specialized rehabilitative services to disabled veterans. Again, the continuum serves to assist VA in achieving its statutory obligations.

The continuum of care does not change eligibility for care, but does identify much earlier those veterans at risk for visual impairments or already beginning to experience visual loss. Additionally, the continuum is also responsive to the Secretary's and Under Secretary for Health's concerns by improving the special emphasis programs they have identified.

The Gold Ribbon Panel appointed in 1998 by the Under Secretary for Health (USH) to explore more effective means of integrating the delivery of blind rehabilitation services into the network concept of healthcare delivery recommended, and the USH approved, the establishment of a full continuum of care for visually impaired veterans. The VIAB was charged with developing an implementation plan for providing a full continuum of care.

The Blinded Veterans Association, the only Federally chartered veterans service organization exclusively dedicated to assisting America's blinded veterans and their families has adopted numerous resolutions in recent years calling for the expansion of VA outpatient vision rehabilitation services.

The establishment of a full continuum of care for visually impaired and blind veterans is consistent with the VA shift from a hospital-based (acute care) system of delivery to an outpatient or ambulatory system of healthcare delivery. Enhancements in healthcare delivery over the years and the changing demographics of an aging veteran population demanded this shift be accomplished. The establishment of a full continuum of vision rehabilitation services will assure visually impaired and blind veterans will receive the most appropriate care.

XI. BUDGET OR FINANCIAL CONSIDERATIONS OF THE RECOMMENDED OPTION:

One area of greatest impact for this continuum of care model is financial. Under VERA 10, the Blind Rehabilitation allocation is based on two VERA patient classes. The Legally Blind patient class is placed in VERA Basic Price Group 4. For FY 2006, allocation for Priority 1-6 is \$6,210 and for Priority 7&8 is \$3,100. The Legally Blind patient class is based on diagnosis criteria. This class includes patients who were not included in a patient class higher in the classification hierarchy and whose inpatient or outpatient care indicates that the patient has specific types of legal blindness. The Blind Rehabilitation Service Patient Class is placed in VERA Complex Price Group 8. For FY

2006, allocation rates for Priority 1-6 is \$25,775 and for Priority 7&8 is \$20,278. The Blind Rehabilitation Service Class is based on utilization criteria that equates to one overnight stay (or one BDOC) in a Blind Rehabilitation Service. The classification timeframe is annual.

With this proposed model, the continuum of care for visually impaired veterans will have an impact on costs for not only those outpatient veterans who are legally blind, but also for those veterans who are determined to have low vision. The increased ability to treat the patient at the early stages of vision loss should prevent more expensive treatment options such as inpatient hospitalizations due to complications associated with vision loss. The funding proposed here will allow Networks to begin to build this continuum of care, but they will have to sustain these services with VERA allocations.

XII. PUBLIC RELATIONS OR MEDIA CONSIDERATIONS OF THE RECOMMENDED OPTION:

Assuring the legally blind veteran population and the Blinded Veterans Association that services to legally blind veterans will not be reduced, but rather that services will be available earlier in the spectrum of vision loss should be a positive and appreciated development. New services will be added in a unique continuum that will benefit all veterans with low vision and legal blindness. VA would be an industry leader by addressing this continuum.

XIII. CONGRESSIONAL OR OTHER PUBLIC OFFICIAL OR AGENCY CONSIDERATIONS OF THE RECOMMENDED OPTION:

None Known.

XIV. IMPLEMENTATION:

VISNs will develop initial plans based on the Gap Analysis conducted by the VIAB and should be required to develop a plan that stays within the total resources identified in that assessment. Plans should be approved by the Blind Rehabilitation Program Office, Rehabilitation Strategic Healthcare Group.