

## BLIND REHABILITATION OUTPATIENT SPECIALIST PROGRAM PROCEDURES

- 1. REASON FOR ISSUE:** This Veterans Health Administration (VHA) Handbook provides procedures for all matters regarding the Blind Rehabilitation Outpatient Specialist (BROS) Program.
- 2. SUMMARY OF MAJOR CHANGES:** This Handbook contains a new section, paragraph 6, that outlines the blind and vision rehabilitation continuum of care. This section provides an algorithm to clarify services, service areas, coordination of care, oversight and accreditation for this program. The definition of excess disability is updated to provide clearer guidelines on who should be involved in the decision making process. Sections related to professional competencies are also updated to reflect the 2010 Blind Rehabilitation Service Hybrid Title 38 qualification standard.
- 3. RELATED ISSUES:** VHA Handbook 1174.02, Blind Rehabilitation Service National Program Consultant Procedures; VHA Handbook 1174.03, Visual Impairment Services Team Program Procedures; VHA Handbook 1174.04, Blind Rehabilitation Center Program Procedures; VHA Handbook 1174.05, Outpatient Blind and Vision Rehabilitation Clinic Procedures; VHA Directive 2011-040, Referral to Inpatient Blind Rehabilitation Centers and Calculation of the Waiting Time Prior to Admission.
- 4. RESPONSIBLE OFFICE:** The Office of Patient Care Services, the Deputy Chief Officer, Rehabilitation & Prosthetic Services (10P4R) is responsible for the contents of this VHA Handbook. Questions may be referred to the Director, Blind Rehabilitation Service at 202-461-7444.
- 5. RESCISSIONS:** VHA Handbook 1174.01, dated September 12, 2008 is rescinded.
- 6. RECERTIFICATION:** This VHA Handbook is scheduled for re-certification on or before the last working day of February, 2021.

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Under Secretary for Health

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## **BLIND REHABILITATION OUTPATIENT SPECIALIST PROGRAM PROCEDURES**

### **1. PURPOSE**

This Veterans Health Administration (VHA) Handbook describes the procedures for the provision of services by Blind Rehabilitation Outpatient Specialists (BROS).

**AUTHORITY:** 38 U.S.C. 7301(b).

### **2. BACKGROUND**

a. In 1995, VHA established the BROS program in the VA Blind Rehabilitation Service (BRS) continuum of care. Prior to the establishment of the BROS program, Veterans and Servicemembers could only receive blind rehabilitation services in the VHA inpatient blind rehabilitation centers (BRCs). BROS services were developed to provide blind rehabilitation outpatient care to Veterans and Servicemembers whose rehabilitation needs are best met in their homes and local areas, and to complement the blind rehabilitation training provided at the BRCs. BROS independently conduct assessments and training in the patients' best environment of care to meet their individual needs.

b. Combat in Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND) has resulted in new patterns of polytraumatic injuries and disability. Recognizing the specialized clinical care needs of these individuals, VA has established a Polytrauma System of Care composed of Polytrauma Rehabilitation Centers (PRC), Polytrauma Rehabilitation Network Sites (PNS), Polytrauma Support Clinic Teams and Polytrauma Points of Contact at selected VA facilities. BROS serve as a member of the interdisciplinary team at the PRC and PNS, contributing their blind and vision rehabilitation expertise to assure the provision of comprehensive rehabilitation.

### **3. SCOPE**

a. BROS services are designed to provide blind and vision rehabilitation care for severely disabled visually impaired Veterans whose rehabilitation needs are best met in their local areas. BROS services are also designed to complement the rehabilitation services provided by the VHA BRS continuum of care as well as blind rehabilitation services provided by non-VA programs in the community.

b. BROS conduct assessments, develop rehabilitation plans, and provide training and evaluations in the Veteran's best environment of care. This program design supports an effective continuum of care by providing individualized rehabilitation in locations that are accessible, and in settings that are most appropriate for Veterans.

c. BROS serve as interdisciplinary team members at polytrauma clinical programs. They contribute their knowledge and skills in blind and vision rehabilitation to comprehensive programs for individuals with complex physical, cognitive, and mental health sequelae of severe and disabling trauma.

#### 4. DEFINITIONS

a. **Blind Rehabilitation Center.** A Blind Rehabilitation Center (BRC) is a specialized inpatient organizational unit in a VA medical center providing comprehensive and individualized rehabilitation programs for blind and visually impaired Veterans and Servicemembers receiving VA services under contractual arrangement. An interdisciplinary team approach is used in a peer support environment. Team members focus their efforts on promoting health, developing skills of independence, and improving the severely visually impaired Veteran's adjustment to sight loss with the ultimate goal of successfully reintegrating the individual within the family and community environment.

b. **Blind Rehabilitation Outpatient Specialist.** A Blind Rehabilitation Outpatient Specialist (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). BROS are VA 601 series professionals who practice under Hybrid Title 38 qualification standards.

c. **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 people 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 people who are visually impaired. BRS are VA 0601 series professionals who practice under Hybrid Title 38 qualification standards. The following therapists, instructors, and case managers within the VHA system are BRS:

- (1) Orientation and mobility (O&M) specialists;
- (2) Low vision therapists;
- (3) Vision rehabilitation therapists (formerly known as rehabilitation teachers for the blind);
- (4) Manual skills instructors;
- (5) Computer access training (CAT) instructors; and
- (6) Visual Impairment Services Team (VIST) Coordinators.

d. **BROS Annual Report.** An annual report is completed by each BROS and submitted to BRS, VA Central Office, through local administrative channels. The report

details program developments, program highlights, program goals and provides a venue for the BROS to indicate how BRS can provide support. A copy of the report is sent to the BRS National Program Consultant responsible for the designated area and is due no later than October 31st of each year.

e. **Commission on Accreditation of Rehabilitation Facilities**. Commission on Accreditation of Rehabilitation Facilities (CARF) serves as the international standards setting and accreditation body promoting the delivery of quality rehabilitation services for people with disabilities. CARF is the accrediting body for VHA rehabilitation programs.

f. **Computer Access Training**. Computer Access Training (CAT) this instructional area provides training in the use of specialized access equipment necessary for a visually impaired person to independently operate computers and achieve their communication goals.

g. **Continuum of Care**. The continuum of care for visually-impaired Veterans refers to vision and blind rehabilitation services ranging across multiple levels of care and services, including: basic outpatient low vision care provided by eye care providers; intermediate and advanced outpatient low vision care involving a team of eye care providers and rehabilitation professionals; as well as interdisciplinary outpatient and inpatient blind rehabilitation programs. Services may be provided in the patient's home and community as well as VA medical facilities. Case management includes screening for psychosocial needs, information, and referral to VA and community resources, benefits review, and adjustment counseling. Veterans and Servicemembers are referred to the program(s) that best match their functional needs.

h. **Episode of Care**. An episode of care (EOC) is set of services required to manage a specific condition over a defined period of time. For a blind Veteran, an EOC includes pre-admission care; assessments, examinations and evaluations; rehabilitation planning; interventions; outcomes assessment and discharge planning.

i. **Excess Disability**. Excess disability describes the functional losses and problems of a Veteran who is not legally blind, but whose functional needs require the services of a VIST and VIST Coordinator, and/or a BROS, and/or an inpatient BRC. Excess disability refers to problems and task performance difficulties related to vision loss that significantly impact the Veteran'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. Veterans whose vision is better than legal blindness may have excess disability due to:

- (1) Sudden and/or traumatic visual disorder (especially related to military service);
- (2) Disabling co-morbidities (e.g., hearing impairment, mobility impairment, etc.);
- (3) Systemic diseases that cause fluctuating visual impairment;

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

(5) Sudden changes in caregiver status; or

(6) Other reasons.

**NOTE:** A patient is categorized as having excess disability by the VIST Coordinator, with input from the station's VIST. Excess disability categorization is based on functional difficulties that require VIST case management as well as intense blind rehabilitation techniques and/or technology. A Veteran may receive care for excess disability on a temporary or ongoing basis. For a detailed discussion of eligibility for BROS services, see paragraph 7.

j. **Eye Care Provider.** An appropriately credentialed and privileged optometrist or ophthalmologist.

k. **Hoptel Program.** A hoptel program is a VA medical center program in which eligible patients may be provided a hospital bed as an outpatient lodger (or alternatively, stay in a nearby hotel/motel), as authorized by 38 C.F.R. part 60. Such eligible patients may receive safe, comfortable lodging but do not receive medical care from physicians or nurses during their stay.

l. **Legal/Statutory blindness.** For purposes of this program and policy, VHA adopts and uses the Social Security Administration's definition of legal/statutory blindness. See 20 C.F.R. Part 404, Subpart P, App. 1, Section 2.00 (Special Senses and Speech). This means that legal/statutory blindness exists when best corrected central visual acuity in the better-seeing eye with correction is less than or equal to 20/200, or 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. Reliance on SSA's definition ensures that Veterans receive appropriate rehabilitation for blindness in a manner aligned with state and external programs for the blind.

m. **Living Skills.** "Living skills" is the instructional area that focuses on communication ability and activities of daily living. These skills encompass a broad range of activities including but not limited to:

(1) Personal grooming;

(2) Eating skills, food preparation, household management; and

(3) Communication skills such as Braille, keyboarding, handwriting, and reading with the use of electronic scanners.

n. **Low Vision.** Low vision exists when the best corrected central visual acuity of 20/70 to 20/160 or worse in the better seeing eye; or significant visual field loss; or a combination of visual acuity, visual field loss, contrast sensitivity loss, loss of stereopsis, or eye motility impairment that impacts patient safety or impairs or restricts one or more activities of daily living.

**Low Vision Clinical Examination.** A low vision clinical examination is performed by an eye care provider. The examination provides the following:

- (a) Determination of the Veteran's level of visual impairment and current visual functioning;
- (b) Best possible optical refractive correction;
- (c) Determination of the patient's ability to benefit from adaptive vision training; and
- (d) Prescription of optical low vision devices.

o. **Low Vision Therapy.**

(1) Low vision therapy is the instructional area that addresses the needs of Veterans with reduced vision that is useful for daily functioning. Low vision therapists enable Veterans to gain a better understanding of their eye problems, assess the use of visual motor and visual perceptual skills and instruct patients in effective use of their remaining vision through techniques that improve visual perceptual and visual motor function for daily tasks.

(2) Visual skills training includes:

- (a) Assessing daily tasks that require using vision;
- (b) Planning an interdisciplinary rehabilitation program to meet the patient's goals for using vision; and
- (c) Partnering with eye care providers to provide intervention with visual techniques, special low vision devices, and ergonomic enhancements designed to promote the use of vision for meeting the patient's goals.

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

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

p. **Manual Skills.** The instructional area designed to enhance ability in sensory awareness and integration with motor skills with an emphasis on adaptive and safety techniques. Skill training focuses on organization, tactual awareness, spatial awareness, use of visual skills, memory sequencing, problem solving, and enhanced confidence. Activities range from basic tasks using hand-held tools to advanced tasks using power tools and woodworking machinery.

q. **National Program Consultants.** National Program Consultants (NPC) are professional field representatives of the BRS Director. The NPC provide ongoing

support and consultative services to the entire BRS continuum of care (inpatient BRCs, outpatient clinics, BROS and VIST).

r. **Ocular Health Examination.**

(1) This examination, conducted by an eye care provider, identifies the level of, and reasons for, a Veteran's visual impairment. 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) Assurance that all ocular and visual disorders are being appropriately managed.

(2) If there is a significant visual field loss, a Goldmann Perimeter, Humphrey Field Analyzer, or equivalent device, is used to determine the extent of the field loss according to the Veterans Benefits Administration (VBA) Fast Letter 06-21 on Measurement of Visual Fields.

(3) Prescription of optical low vision devices.

(4) Participating in interdisciplinary teams with other professionals to assure appropriate vision care and vision rehabilitation.

s. **Optical Low Vision Devices.**

(1) Optical low vision devices alter the image focus, size (magnification or minification), contrast, brightness, color, or directionality of an object through the use of ophthalmic lenses.

(2) Optical low vision devices must be prescribed by an eye care provider.

t. **Orientation and Mobility.** Orientation and Mobility (O&M) is the instructional area that addresses the establishment and maintenance of orientation to the environment, as well as safe, efficient, and confident movement in the environment. Veterans use all senses, available environmental information, protective techniques, and access technology for orientation and way finding.

u. **Polytrauma Blind Rehabilitation Outpatient Specialist.** A Polytrauma BROS is a professional whose expertise is required by policy and practice in the centers and sites of VHA's Polytrauma System of Care. Polytrauma BROS are embedded within the interdisciplinary treatment team to assess, plan, treat and determine outcomes at Polytrauma-traumatic brain injury (TBI) Centers, Transitional Rehabilitation Program and Network Sites. Polytrauma BROS meet the Hybrid Title 38 qualification standards for BROS, and demonstrate specialized knowledge and skills in blind and vision rehabilitation related to TBI.



v. **Polytrauma System of Care.** The VA Polytrauma System of Care provides patients comprehensive, high quality, interdisciplinary care for patients with multiple physical, cognitive, and/or emotional injuries secondary to trauma (e.g., accidents, blast exposure, etc). Teams of physicians and rehabilitation practitioners from every relevant field plan and administer an individually tailored rehabilitation plan to help patients recover as much as possible. The patient and family/caregiver are informed of the team's findings and are involved with developing recommendations for goals and expectations for rehabilitation. The team also meets in weekly rounds to evaluate the patient's progress and to adjust or redefine the treatment goals accordingly. The Polytrauma System of Care includes 5 Polytrauma Rehabilitation Centers (PRC), 5 Polytrauma Transitional Rehabilitation Programs (PTRP), 23 Polytrauma Network Sites (PNS), 87 Polytrauma Support Clinic Teams (PSCT), and 39 Polytrauma Points of Contact (POC).

w. **Visual Impairment Services Outpatient Rehabilitation.** Visual Impairment Services Outpatient Rehabilitation (VISOR) is a VA outpatient hopitel blind rehabilitation program that provides blind and vision rehabilitation with an interdisciplinary team. The team includes a program chief, low vision therapist, O&M specialist, vision rehabilitation therapist, CAT instructor, and an eye care provider.

x. **Visual Impairment Services Team.** A Visual Impairment Services Team (VIST) is comprised of medical, associated health care, and other professionals and consumers charged with the responsibility of ensuring that blind Veterans are identified, evaluated, and provided health and rehabilitation services to maximize adjustment to sight loss. Team representatives may include, but are not limited to: social work, ophthalmology, optometry, prosthetics, primary care, vocational rehabilitation, library service, nursing, audiology, podiatry, dietetics, psychology, physical medicine and rehabilitation, Veterans Benefits Association representatives, blind Veterans' consumer organizations, blind consumers, and state and community agencies' representatives for people who are blind.

y. **Visual Impairment Services Team Coordinator.** The VIST Coordinator serves as the case manager who has major responsibility for the coordination of services for severely disabled visually impaired Veterans and their families. Their duties include:

(1) Arranging appropriate rehabilitation services in order to enhance a visually impaired Veteran's functioning level (e.g., referrals to the VA's continuum of care as well as to outsourced services in order to enhance the Veteran's abilities);

(2) Identifying new cases of blindness;

(3) Providing adjustment counseling and support services for Veterans;

(4) Meeting specific objectives established by the VIST;

(5) Arranging VIST annual reviews;

(6) Reviewing and assuring Veterans benefits;

(7) Conducting educational programs relating to VIST and blindness;

(8) Developing and disseminating a VIST newsletter; and

(9) Facilitating VIST meetings and distributing minutes.

(10) Informing Veterans about available of non-VA services and benefits in the community.

z. **Visual Impairment Services Team Annual Review.** A process that includes a physical examination, eye examination, and VIST Coordinator interview during which a blind Veteran's needs are identified and the Veteran is advised of the full range of services and/or benefits for which s/he is eligible. The VIST assessment addresses a patient's history, current skill level, adjustment to blindness issues and current needs. The VIST Coordinator formulates a description of the Veteran's functional capabilities and limitations, and develops a treatment plan that includes recommendations for other needed examinations, services, information and education for Veteran and family, and follow-up.

## 5. AUTHORIZED BROS SERVICES

a. **Rehabilitation Care.** Blind and vision rehabilitation EOC are authorized. For BROS services, an EOC includes:

b. **Pre-admission Care.** Each patient receives information concerning the BROS program, application status, first appointment date, patient rights and a description of the services to be provided.

c. **Assessments, Examinations, and Evaluations.**

(1) Each patient receives an intake interview in order to develop a problem list of functional difficulties caused by visual impairment. The intake interview is followed by assessments and evaluations of the use of vision and other learning modalities related to the Veteran's problems and goals for daily activities.

(2) An assessment is conducted in each of the blind and vision rehabilitation skill areas appropriate to the Veteran's goals. Assessment and evaluation may include utilizing both standardized formal instruments and non-standardized informal instruments. An assessment and evaluation addresses the patient's strengths, needs, preferences, and desired outcomes, and also includes 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 is incorporated.

(3) The BROS may conduct an evaluation prior to the Veteran entering an inpatient (BRC) or outpatient (VISOR) clinical blind rehabilitation program. A comprehensive evaluation includes assessments in O&M, living skills, manual skills, visual skills, safety, and (when indicated) computer access. The assessment format is mutually developed by the BROS and the BRC or VISOR staff. During the evaluation, the BROS assesses

each Veteran's abilities and needs for blind rehabilitation training, and addresses the Veteran's goals and readiness for clinical blind rehabilitation care.

(4) The BROS must ensure that Veterans with remaining sight receive a low vision clinical examination and an evaluation of visual motor and visual perceptual skills in conjunction with an eye care provider. The BROS will work with the eye care provider to develop a visual rehabilitation treatment plan utilizing optical low vision devices prescribed by the eye care provider as well as any other visual skill training, technology and equipment that enhances and supports the use of vision.

d. **Rehabilitation Planning.** The BROS, working within an interdisciplinary team framework and together with the Veteran and family/caregiver, develops an integrated and coordinated plan of care for the Veteran. The plan specifies the problems and rehabilitation goal(s) of the patient with the family/caregiver, a description of the planned interventions that the patient is to receive to achieve the goal(s), the patient and family/caregiver 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. The BROS continually evaluates 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.

e. **Interventions.**

(1) BROS who have demonstrated the required education, credentials and competencies are authorized to provide blind and vision rehabilitation instruction and training in a variety of settings. BROS are authorized to provide blind rehabilitation training within their scope of practice in the following blind rehabilitation skill areas: living skills, manual skills, O&M, low vision therapy, and computer access. Polytrauma BROS provide interventions related to sequelae of TBI, within their scope of practice, as a part of an interdisciplinary team. The BROS training program includes instruction in the use of access technology and devices, including personal computers. BROS provide interventions to assist patients in achieving their goals for independence, quality of life, and family and community integration. Interventions may include, but are not limited to: new skill development, opportunities for adjustment to vision loss, learning the use of prescribed optical devices and other devices and technology, care of devices and technology, 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 and rehearse the intervention in practice, and use the intervention in real life situations and environments.

(2) Adjustment counseling is an important intervention that assists Veterans in coping with the onset of visual impairment. Various professionals assist visually impaired Veterans in adjustment to sight loss. BROS, who are educated to recognize and treat the social and psychological dynamics of visual impairment, integrate

appropriate adjustment strategies into their instruction. BROS partner with VIST Coordinators, social workers, and other mental health professionals to ensure that Veterans' care management, adjustment, and psychosocial concerns are assessed and treated effectively.

(3) Special programs may be offered for Veterans who have previously completed a 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 BROS may offer a targeted training program to meet that specific need, if determined appropriate.

(4) BROS partner with other medical professionals to assure that blind Veterans develop appropriate knowledge and skills in using devices and technology that may be prescribed / recommended for medical regimens and/or other disabilities. For example, BROS partner with the prescribing medical professionals to assure that blind Veterans are able to correctly and efficiently use audible prescription reading devices, medication management devices, talking blood pressure machines, talking weight scales, support canes, accessible glucometers, syringe adaptations, assistive listening devices, etc.

(5) Veterans may also require a service that does not necessitate a clinical appointment, such as replacement of prosthetic devices, telephone or secure messaging exchanges, brief advice, etc.

f. **Outcomes Assessment and Discharge Planning.**

(1) Each Veteran (and family member or caregiver when appropriate) is to be included in an evaluation of relative success in achieving the goals and outcomes specified on the BROS rehabilitation plan. Veterans will be provided with opportunities to indicate their satisfaction with the program and to provide any input for program improvement. A discharge plan will be developed with the Veteran and family member or caregiver to address the concerns of the Veteran following an EOC, and to ensure that the Veteran understands:

(a) How to contact the VIST Coordinator who will provide follow-up case management (which may include transitioning to community programs, VA BRS outpatient or inpatient programs, etc.);

(b) Veteran and family/caregiver responsibilities for any further practice required at home;

(c) Use and care for any prescribed and recommended prosthetic devices as well as contact information in case ordered prosthetic items are not received when expected;

(d) Any referrals to other professionals and their contact information; and

(e) Future appointments in the vision or blind rehabilitation programs (if any).

(2) The patient will receive a written copy of the discharge plan to assure that s/he knows what to expect when an EOC has been completed, and is directed to contact the

VIST Coordinator for any future needs. Circumstances under which a Veteran may be discharged from the program include, but are not limited to:

- (a) Goals and objectives have been achieved;
- (b) Progress plateaus;
- (c) Veteran declines further service; or
- (d) Veteran is unable to participate in further service.

g. **Prosthetic Issuance.** BROS who have been formally trained to assess the use of and 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 of prosthetic devices within their scope of practice if a device allows the Veteran to meet a goal after the Veteran has demonstrated the ability to effectively use and care for the appliance. Optical low vision devices can only be prescribed by an eye care provider. Medical devices such as audible prescription reading devices, talking glucometers, blood pressure cuffs, etc. are likewise only prescribed by physicians and/or nurses (consistent with their privileges). The BROS will partner with a Veteran's medical and/or nursing provider to assure that blind Veterans are assessed and instructed in the correct and safe use of those and similar medical devices.

h. **Support for Veterans' Access to Non-VA Services and Benefits.** The BROS must collaborate with the local VIST Coordinator to ensure that eligible blind Veterans are aware of services and benefits available to them outside the VA. The VIST Coordinator is responsible for informing the Veteran about available non-VA services and benefits in the community. When appropriate, a BROS will assist in the Veteran's application for such services.

i. **Support for BRS Continuum of Care and BRS National Program Office.** The BROS must maintain effective communication with the VIST Coordinator and any other involved professional/s to maximize the Veteran's blind rehabilitation outcomes. The BROS must:

- (1) Be flexible to the changing needs of the overall blind and vision rehabilitation service delivery system;
- (2) Be responsive to the input of the NPC who are responsible for support and oversight of BROS care; and
- (3) Respond to requests for information and participate in projects in support of BRS national program office initiatives.

j. **Staff Education and Community Outreach.** As subject matter experts in the field of blindness, the BROS and VIST Coordinator collaborate to provide education and training for professionals inside and outside the VA, lay persons, fellow blind rehabilitation practitioners, blindness consumer groups, blindness-related professional

and membership organizations, community service organizations, eye care and geriatric organizations, rehabilitation organizations and other community outreach.

k. **Home Assembly of Equipment.** Veterans may require assistance with home assembly of equipment. Although independent assembly of equipment is desirable and is included in the Veteran's clinical care plan, assistance with assembly may be indicated due to a Veteran's physical limitations. If assembly is necessary, the process may require coordination among the BROS, VIST Coordinator, local vendor(s), BRC, VA Prosthetic and Sensory Aids Service (PSAS), other rehabilitation or home health practitioners, Veteran and family, or caregiver.

## 6. BROS OUTPATIENT MODEL OF CARE

a. **Services.** In the BROS model, severely disabled visually impaired Veterans receive blind rehabilitation services through local assessment and training to:

(1) Meet the immediate needs of the Veteran which impact safety (e.g. mediating falls risk, safety from sharps and burns, and compensatory techniques for medication management, etc.);

(2) Prepare for, or transition from, an inpatient episode of care in a blind rehabilitation center or an outpatient episode of care in a VISOR program; and

(3) Provide blind rehabilitation for Veterans whose training needs are best met in their local community.

b. **Service Area.** Each BROS (who is not practicing in the Polytrauma System of Care) has a defined geographic service area. In most cases, the primary service area corresponds to the service area for the VA facility where the BROS is located. However, BROS programs may serve one or more VA facilities, as resources and needs indicate. BROS serving at a polytrauma clinical program may have additional duties related to Polytrauma that include areas larger than the typical BROS geographic boundaries.

c. **Coordination of care.** VA medical facilities housing BROS shall coordinate the provision of VA blind rehabilitation services with services (for blind Veterans) being provided by state and local agencies at VA-expense. (Such non-VA services are to be of similar quality as those available through VA and obtained at similar cost.) In coordinating the delivery of services, BROS are to ensure that both the VA and non-VA services are delivered in a manner that meets the needs of the blind Veterans, e.g. delivered in settings located close to the Veterans' residences.

d. **Oversight and Accreditation.**

(1) The BROS may be surveyed by the Joint Commission. All BROS programs are required to comply with applicable Joint Commission home care standards.

(2) The BROS may also be surveyed by CARF to review follow-up care after an inpatient or outpatient blind/vision rehabilitation experience.

(3) BROS must demonstrate that they are providing safe, high quality care, as determined by compliance with applicable standards, National Patient Safety Goals recommendations, and performance measurement requirements.

(4) The NPC provide oversight and support for BROS in their region. The NPC (in partnership with the BROS supervisor and facility administration) may: review workload, provide chart reviews and other evaluations of documentation and care, perform site visits, recommend start-up and annual budgets and equipment, and provide other services as required.

## 7. CLINICAL ELIGIBILITY FOR BROS SERVICES

a. BRS is committed to serving all enrolled and otherwise eligible Veterans who need and can benefit from these services. Legal blindness based on measurement of visual acuity and visual fields has long been recognized as an indicator of disability, and it continues to be a primary indicator of clinical eligibility for VHA blind rehabilitation services for severely disabled visually impaired Veterans and Servicemembers. Clinical eligibility criteria for blind rehabilitation services must also address functional deficits and the rehabilitation needs of the Veteran because of the complex relationship between visual function and overall functional capacity of a Veteran who is blind. Therefore, BROS may also provide care for an enrollee with excess disability who is not legally blind. VA BROS may also provide these services to eligible Servicemembers (pursuant to a 2009 DoD-VA Memorandum of Agreement). In order for a Veteran to be eligible for BROS services, the Veteran must be enrolled in the VIST program and:

(1) Determined to meet the criteria for legal blindness, or

(2) Determined by the VIST Coordinator, with input from the Visual Impairment Services Team, to meet the criteria for excess disability (i.e., inpatient BRC, VISOR and/or BROS services are required to address the individual's safety and functional independence, and to facilitate personal or social adjustment to vision loss).

b. A categorization of excess disability is not based on clinical measurements but requires functional assessment and evaluation. Excess disability is related to problems and task performance that significantly impacts the Veteran's functional independence or personal safety. Categorization of excess disability on behalf of a Veteran requires thoughtful analyses and input by the VIST members. A categorization of excess disability in most cases will require input from other medical, nursing, rehabilitation, and case management practitioners. The VIST Coordinator must understand the severity, impact and temporal nature of conditions that contribute to excess disability. Information from a variety of other blind rehabilitation practitioners, and the NPC, will be vital in the VIST Coordinator's decision-making. Veterans' excess disability may be temporary, may occur periodically, and may resolve if vision improves, or other co-morbidities or life difficulties resolve.

c. After seeking and obtaining input from all relevant VIST members, the VIST Coordinator:

- (1) Makes a final decision about the categorization of excess disability,
- (2) Records the decision and an explanation for its basis/bases in the patient's record,
- (3) Makes a decision with the Veteran (and family/caregiver) about the care needed (e.g., case management, BROS services, BRC), and
- (4) Makes a referral to the program of care in which the Veteran may receive the blind/vision rehabilitation services that best addresses the excess functional needs.

## 8. PRIORITY OF CARE

a. In scheduling appointments for outpatient medical services and admission, priority is to be given to (1) Veterans with service-connected disabilities rated 50 percent or greater based on one or more disabilities or unemployability; and (2) Veterans needing care for a service-connected disability.

b. For purposes of the scheduling priority discussed above, medical necessity may include consideration of factors, such as:

- (1) Patient Safety issues,
- (2) Medical issues,
- (3) Chapter 31 Vocational Rehabilitation needs ) per 38 CFR 17.47(i), or
- (4) No previous history of blind/vision rehabilitation services.

## 9. VHA SUPPORTIVE SERVICES

a. **VA Medical Facilities.** The BROS and VIST Coordinators are key links between the VA medical facility, visually impaired Veterans and their families, and the community. They serve as a powerful connection for visually impaired Veterans in accessing the benefits and services of VHA. The BROS and VIST Coordinators provide training and input for medical facility staff in the nature of blindness and its impact on patient care, assure that all medical facility staff understands the access issues related to blindness, and provide expertise in all aspects of accessibility for blind Veterans. They may serve on committees and workgroups to assure that the needs of blind Veterans and their families are considered in all aspects of patient care.

b. **Ophthalmology and Optometry Services.** Eye care providers perform ocular health examinations, low vision clinical examinations, treatment and management of ocular diseases and vision disorders as appropriate, and determination of clinical vision functions. Ophthalmologists and Optometrists prescribe all optical low vision devices and may provide basic instruction in their use. They are also responsible for identifying and documenting legal blindness. The BROS and eye care staff work collaboratively as an interdisciplinary team to ensure that Veterans receive appropriate vision rehabilitation services in the BRS continuum of care.



c. **Prosthetic and Sensory Aids Service.** Prosthetic and Sensory Aids Service (PSAS) provides prosthetic technology equipment, and supports BROS by maintaining sufficient stock to ensure prompt availability. BROS who are O&M specialists may recommend that patients attend guide dog schools for evaluation of a guide dog (following the PSAS recommendation policy) and may be involved in the review and updating of VA facility service and guide dog policies and provisions.

d. **Visual Impairment Services Team Coordinator.** The VIST Coordinator partners with VA medical facility services to:

(1) Identify and screen visually impaired Veterans, and assisting as necessary with enrollment in VA health care. VIST Coordinators provide a needs assessment, evaluate the Veteran's adjustment to vision loss and coping strategies, and partner with members of the VIST to assure that blind Veterans receive all the VA services and benefits to which they are entitled/eligible. VIST Coordinators are responsible for making the functional designation of excess disability with input from the VIST members and documenting the categorization in the patient's record; noting the reasons for the categorization and whether the category is expected to be temporary or permanent.

(2) Ensure that eligible Veterans are aware of services and benefits available to them through VA and non-VA sources, and when appropriate, assisting Veterans in their applications for services.

(3) Recommend prosthetic equipment for severely disabled visually impaired Veterans who may or may not be participating in the BROS or BRS clinical programs in accordance with VHA Handbooks, VHA Directives, and VHA Prosthetic Clinical Management Program (PCMP) Clinical Practice Recommendations policies.

(4) Coordinate care with BROS for severely disabled visually impaired Veterans who require BROS services.

(5) Coordinate community-based program training activities of Veterans currently active in the BROS Program.

(6) Serve as a liaison with local non-VA agencies and organizations, together with the BROS, to assist in the identification and/or provision of services to severely disabled visually impaired Veterans. The VIST Coordinator has primary responsibility for making referrals and monitoring the progress of services provided by these agencies with assistance from the BROS and eye care providers.

(7) Coordinate the VIST activities.

(8) Publish a newsletter for severely disabled blind Veterans in their catchment area.

e. **Inpatient Blind Rehabilitation Center.** The inpatient Blind Rehabilitation Center (BRC) is responsible for:

(1) Coordinating the admission date, treatment planning, and post-discharge care with the VIST Coordinator in a timely manner for Veterans according to VHA policy. A

BROS may also be involved in the treatment planning and/or post-discharge care if the BROS has provided pre-BRC care or is to provide post-BRC care.

(2) Providing interdisciplinary assessment and evaluation, planning, and intensive, comprehensive blind rehabilitation for severely disabled visually impaired Veterans and Servicemembers.

(3) Providing training for BROS.

f. **Outpatient Blind Rehabilitation Clinics.** The Visual Impairment Services Outpatient Rehabilitation (VISOR) is responsible for:

(1) Coordinating the appointments, treatment planning, and post-discharge care with the VIST Coordinator in a timely manner for Veterans according to VHA policy. A BROS may also be involved in the treatment planning and/or post-discharge care if the BROS has provided pre-VISOR care or is to provide post-VISOR care.

(2) Providing interdisciplinary assessment and evaluation, planning, and blind rehabilitation for severely disabled visually impaired Veterans and Servicemembers.

(3) Providing training for BROS.

g. **BRS NPC.** The NPC is responsible for:

(1) Assisting in the initial orientation and training of new BROS through direct training and establishment of mentoring programs;

(2) Assisting BROS in personal development plans that address mastery, technical skills, customer services, and other aspects of the VA's High Performance Development Model;

(3) Assisting BROS in effective and efficient service delivery and updates in best practices;

(4) Providing oversight of BROS programs and supporting best practices;

(5) Compiling and analyzing data trends for patient care, workload, and patient demographics;

(6) Providing recommendations for evidence-based best practices;

(7) Ensuring that recommended International Classification of Disease and Current Procedural Terminology coding for blind rehabilitation care are appropriately deployed;

(8) Providing interpretation of VHA policy as they affect BROS practice;

(9) Providing the facility housing a new BROS with a recommended starting

equipment and supply list; and

(10) Providing facilities already housing a BROS with an updated equipment and supply list, and recommendations for ongoing operating funds on an annual basis.

## 10. PROSTHETIC EQUIPMENT AND SENSORY AIDS

a. **Clinical Criteria for Issuance.** Prosthetic devices may be recommended to meet one or more goals for blind/vision rehabilitation care, within BROS' scope of practice. Patients must demonstrate the ability to use and care for the equipment to meet the goal(s). Required documentation includes:

(1) Stated goal(s) for the device,

(2) Assessment and training provided to meet the goal(s),

(3) Capability of the Veteran to utilize the equipment appropriately, and

(4) Capability of the Veteran to care for the equipment, manage minor problems and seek support for difficulties with the equipment.

b. **Recommending Authority.**

(1) The BROS may provide initial issuance of all non-optical vision and blind devices and technology within their scope of practice, provided the Veteran has completed the required training and demonstrated the ability to properly use and care for the recommended equipment and the device/s assist Veteran in achieving rehabilitation goal/s. The initial issuance of optical low vision devices by the BROS requires prescription from an eye care provider.

(2) Requests for prosthetics by non-VA service practitioners as part of community-based programs of instruction should be addressed to, and will be managed by, the VIST Coordinator, who serves as the case manager for the Veteran. The VIST will request co-management by the BROS when necessary.

(3) BROS may provide replacement equipment and equipment upgrades for Veterans who have previously participated, but who are not currently participating, in a VA blind rehabilitation program, provided there is appropriate documentation for the initial issuance of the equipment. Where such upgrades require extensive re-training (e.g., new computer technology), the BROS will inform the VIST Coordinator who will coordinate a referral to the appropriate program, and monitor the Veterans' progress.

## 11. REFERRAL PROCEDURES FOR SEVERELY DISABLED VISUALLY IMPAIRED VETERANS

a. **Identification.** The VIST Coordinator identifies the severely disabled visually impaired Veteran and coordinates services that include an ocular health examination, medical evaluation, audiological examination, psychosocial interview, and patient and family education. The VIST Coordinator completes a VIST assessment, which

describes the Veteran's functional capabilities and limitations and includes a patient history, information about adjustment to blindness, and Veteran's goals for rehabilitation. If a Veteran who is not legally blind is to be evaluated for determination of "excess disability", the procedure in Section 7 is followed.

b. **BROS Program Open Cases According to Priority of Care.** A patient is added to the BROS caseload after a referral has been received from the VIST Coordinator. A Veteran's EOC is completed when the patient's goals and objectives are achieved; the patient's progress plateaus; the patient declines further service; or the patient is unable to participate in further service. If the Veteran has received rehabilitation care in another element of the BRS continuum of care, or to a non-VA agency, and follow-up service by a BROS is anticipated, the EOC will be closed after completion of the BROS follow-up treatment. When the EOC is closed, the BROS will enter a discharge summary in the Veteran's medical record, adding the VIST Coordinator as a co-signer, and provide a copy of the discharge summary to the Veteran.

## 12. WORK ENVIRONMENT, TRAVEL, EQUIPMENT, AND SUPPLIES

a. **Work Environment.** The work environment for a BROS encompasses a wide range of areas including, but not limited to:

- (1) VA facilities,
- (2) Veteran's home and immediate neighborhood,
- (3) Employment sites,
- (4) School campuses,
- (5) Residential areas,
- (6) Rural areas,
- (7) Downtown and urban areas, and,
- (8) Sites of Public transportation.

b. **Office Space.** Each BROS program requires adequate office and clinical space to evaluate and assess patients, demonstrate adaptive equipment, and provide training in multiple skill specialty areas to severely disabled visually impaired Veterans (e.g., visual skills and O&M assessment/training space, space for CCTVs, adapted computer systems and other technology, etc.). The assigned space should be a minimum of 300 square feet and located in an area that is accessible and convenient for blind Veterans.

c. **BROS Travel.** BROS rehabilitation care must be conducted in areas that are specific to the individual needs of Veterans. This requires frequent travel by government vehicle, and public transportation, if available to Veterans. Immediate access to vehicles is important to ensure an efficient rehabilitation process. The VA

medical facility assigns each BROS a government vehicle for this reason. Public transportation rail/bus passes may also be required and must be provided by the VA medical facility where a BROS is located. For BROS in rural areas, overnight travel may promote the most efficient use of BROS face-to-face patient care time. BROS will work with the NPC for the region and the VA medical center Chief of Staff office to determine whether and how overnight travel should be planned and funded.

d. **Budget.** VA medical facilities where BROS are housed provide BROS programs with start-up and ongoing operational funding to purchase training equipment, office equipment, and supplies. The NPC for the region will provide recommendations for equipment, supplies and a reasonable annual budget.

### 13. DOCUMENTATION AND WORKLOAD REPORTING

a. The documentation of patient assessments, treatment plans, and progress notes must be consistent with VA requirements, as well as the requirements of the Joint Commission.

b. The BROS is responsible for ensuring timely and accurate workload capture to include electronic encounter form completion, electronic medical chart progress note/summary documentation (per the requirements for recording an EOC), accurate appointment management in VistA and appropriate case management in the BR 5.0 National Database.

(1) Outpatient appointments should be scheduled in VistA, as required by VHA Outpatient Scheduling Process and Procedures (VHA Directive 2010-027).

(2) The BR 5.0 National Database should be used for:

(a) Updating and completing all referrals to the BROS program;

(b) Creating self-referrals during extended unavailability of a local VIST Coordinator to create the referral (i.e. extended annual leave, extended sick leave, vacancy and/or when the VIST Coordinator and the BROS jointly agree that it works best for the BROS to create self-referrals to ensure seamless and timely patient care);

(c) Entering non-treatment training plan encounters for assessment and training sessions (this should be completed for each training session);

(d) Entering a progress note into the electronic medical record following each patient encounter that indicates: purpose of the BROS encounter with the patient, needs assessment, goal-setting, treatment plan that addresses those goals; interventions; and outcomes;

(e) Documenting a discharge summary in the Veteran's medical record, adding the VIST Coordinator as a co-signer to the discharge summary, and providing the discharge summary to the Veteran and

(f) Recording clinic activity in the BRS national database and in the electronic medical record.

(3) The BROS must submit an annual report. The annual report details program developments, program highlights and program goals for the period of October 1 – September 30, and is sent to the appropriate NPC no later than October 31st of each year.

#### 14. PROFESSIONAL TRAINING

a. VHA provides professional continuing education and training programs for BROS.

b. New BROS must participate in individualized orientation based on their background training and mentoring to enhance skills and develop a cooperative working relationship with all other BRS field elements. The curriculum must include:

(1) Training in policies and procedures related to blind rehabilitation services provided by the NPC, and with the regional BRC program and outpatient clinics in their VISN.

(2) Education in assessment, instruction, technology, evaluation and outcomes measurement according to VHA standards of care. This instruction can primarily be provided at the regional BRC or VISOR program.

(3) Activities that encourage teamwork and facilitate communication between the BROS and other BRS field staff as well as medical facility staff in nursing, physicians, Physical Medicine and Rehabilitation, Audiology and Speech Language Pathology, Prosthetics and Sensory Aids Service, Home Health Care, etc.

(4) Establishment of a mentoring program with oversight of an established BROS and a NPC.

(5) Development of collaborative protocols for serving blinded Veterans in their areas.

#### 15. BROS PROFESSIONAL COMPETENCIES

BROS are VHA 0601 series professionals. Hybrid Title 38 qualification standard requirements for BROS, including education, credentials and knowledge, skills and abilities, are specified in VHA policy.

#### 16. PROGRAM OVERSIGHT

a. **Supervision.** BROS are supervised by the VHA medical facility Chief of Staff or the Chief of Staff designee.

b. **VHA Blind Rehabilitation Service Oversight.** NPCs perform ongoing review and evaluation of BROS programs in their regions to ensure that BROS services are

being provided in an effective and efficient manner. NPC work with the BROS and VA medical facility to assure that the BROS program is conducted according to national standards, that services and workload are within guidelines, and that BROS are supported through feedback and continuing education in best practices and evidence-based care.

c. **Consumer Feedback and Input.** In coordination with the local VIST Coordinator, BROS establish mechanisms to solicit blind and visually-impaired Veteran feedback and input concerning the overall quality of care and services provided to them. This is accomplished by periodic surveys (e.g. uSPEQ<sup>®</sup>, the CARF survey tool deployed within VHA rehabilitation programs), consumer forums, and input from Veteran Service Organizations, and other program stakeholders.

## 17. RECRUITMENT AND PROMOTION

BROS are recruited and promoted according to VHA Human Resources policy and Hybrid Title 38 procedures for BROS.

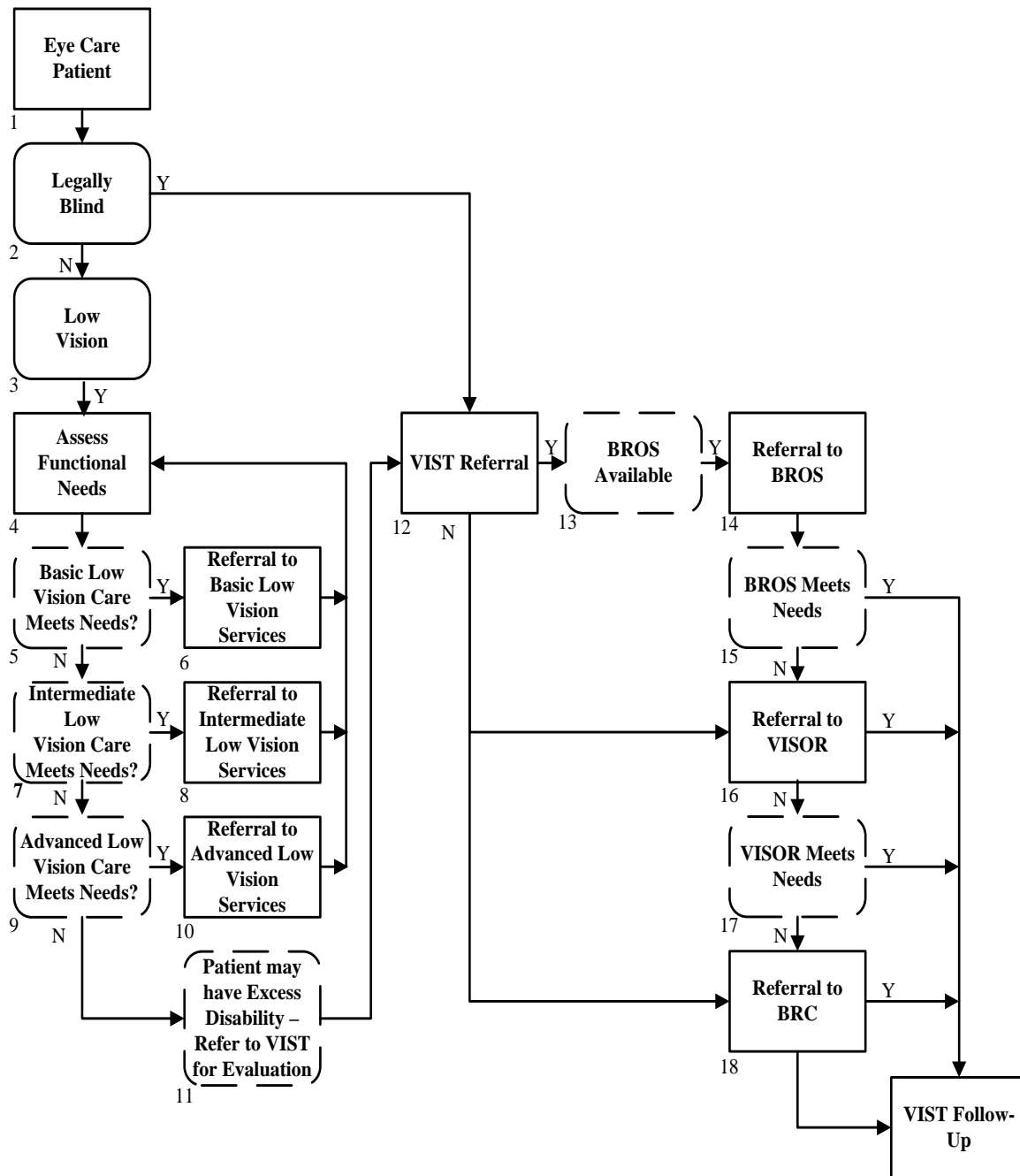
## 18. REFERENCES

- a. VHA Handbook 1174.03, Visual Impairment Services Team Program Procedures.
- b. VHA Directive 2011-040, Referral to Inpatient Blind Rehabilitation Centers and Calculation of the Waiting Time Prior to Admission.
- c. VHA Handbook 5005/48 Part II Appendix G42, Blind Rehabilitation Outpatient Specialist Qualification Standard.
- d. Department of Veterans Affairs and Department of Defense Memorandum of Agreement Regarding Referral of Servicemembers who Sustain Spinal Cord Injury, Traumatic Brain Injury or Blindness to Veterans Affairs Medical Facilities for Health Care and Rehabilitative Services (August, 4 2009) at: ([www.tricare.mil/dvpc/downloads/12-13-06.pdf](http://www.tricare.mil/dvpc/downloads/12-13-06.pdf)).
- e. Optometric Clinical Practice Guidelines (Care of the Patient with Visual Impairment – Low Vision Rehabilitation), American Optometric Association at: (<http://www.aoa.org/x4813.xml>).
- f. Preferred Practice Patterns VISION REHABILITATION, American Academy of Ophthalmology at: (<http://one.aao.org/CE/PracticeGuidelines/PPP.aspx>).
- g. Social Security Disabilities Programs, Medical/Professional Relations, Disability Evaluation under Social Security, 20 CFR Part 404, Subpart P, App 1, Section 2.00 Special Senses and Speechat: (<http://www.ssa.gov/disability/professionals/bluebook/2.00-SpecialSensesandSpeech-Adult.htm>).

- h. Veterans Benefits Administration, Fast Letter 06-21, Measurement of Visual Fields.
- i. VHA Handbook 1173.05, Aids for the Blind.
- j. VHA Handbook 1172.01, Polytrauma System of Care.
- k. VHA Handbook 1121.01, VHA Eye Care.
- l. VHA Prosthetic Clinical Management Program Clinical Practice Recommendations for Audible Prescription Reading Devices.
- m. VHA Prosthetic Clinical Management Program Clinical Practice Recommendations for Prescription of Closed Circuit Televisions and Other Electronic Optical Enhancement Devices.
- n. VHA Prosthetic Clinical Management Program Clinical Practice Recommendations for Prescription and Provision of Daily Living and Mobility Devices for Legally Blind and Visually-Impaired Veterans.
- o. VHA Prosthetic Clinical Management Program Clinical Practice Recommendations on Prescription and Provision of Optical Low vision Devices to Aid in Overcoming Visual Impairment.



### Algorithm for Visually Impaired Veterans



#### ANNOTATIONS TO ALGORITHM

1. Visually impaired Veterans who have a confirmed diagnosis of visual impairment from eye care providers and who are enrolled in VA’s health care system are eligible for

VA care. Veterans with visual impairment are referred to rehabilitation if there is any vision loss affecting daily life that cannot be managed within an eye clinic.

2. Legally blind Veterans are referred to the VIST Coordinators within a VHA medical facility (e.g., by Patient-aligned Care Teams), outside services (e.g., by community or state agencies for rehabilitation), by the Veterans themselves, and by their family members, etc. The VIST Coordinator establishes an eye appointment to assure that the Veteran is legally blind, unless documented in a recent appointment.

3. The term “low vision” includes:

a. Best corrected central visual acuity of 20/70 to 20/160, or worse in the better seeing eye; or

b. Significant visual field loss; or

c. A combination of visual acuity, visual field loss, contrast sensitivity loss, loss of stereopsis, or eye motility impairment that impacts patient safety or impairs or restricts one or more activities of daily living.

4. Veterans with low vision are assessed for their functional needs. This interdisciplinary examination and assessment between blind rehabilitation and eye care providers is a best practice for pairing Veterans’ functional needs with available low vision services.

5. Basic low vision services within the eye clinic include provision of low vision optical devices (e.g., spectacle magnification and some magnification devices) and environmental adaptations (lighting and contrast).

6. Basic low vision services are available in all VHA eye clinics. Training in the use of low vision devices is limited. When the low vision program is completed, patients should be reassessed at their next eye examination to determine whether additional needs have developed.

7. In the intermediate low vision service, a moderate breadth and level of complexity of services and low vision devices are available to the patient. An eye care provider must provide this service, or the eye care provider may directly supervise allied health professionals in some aspects of the clinical low-vision examination and the prescription of devices. A low vision therapist provides rehabilitation assessment and intervention services.

8. Intermediate low vision services are provided in each VISN. When the low vision program is completed, the patients should be reassessed annually to determine whether additional needs have developed.

9. In the advanced low vision clinic, the full spectrum of low vision devices is available for prescription. An eye care provider 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. A low vision therapist will provide rehabilitation assessment and intervention services. An O&M specialist will provide O&M services.

10. Advanced low vision services are provided in at least one site within each VISN. Hoptel or lodging arrangements are provided for Veterans who require them.

11. Excess disability is a term that is used to describe the functional losses and problems of a Veteran who is not legally blind, but who's functional needs require the services of a VIST and VIST Coordinator, and/or a BROS, and/or an inpatient BRC or VISOR program because a low vision service cannot adequately meet the Veteran's needs. Excess disability refers to problems and task performance difficulties related to vision loss that significantly impacts the Veteran'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. 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.

12. A patient is categorized as having excess disability by their VIST Coordinator, with input from the station's VIST. The categorization is based on the rehabilitation needs of the Veteran and in what program those needs are best met - and not on clinical vision function measures alone, such as acuity or visual field.

13. The VIST and the VIST Coordinator will assess the patient using the guidance of VHA Handbook 1174.03 Visual Impairment Services Team Program Procedures, November 5, 2009.

14. Blind Rehabilitation Outpatient Specialists (BROS) are not available at every facility.

15. Where BROS are available, the VIST Coordinator and BROS will partner to determine whether BROS, outpatient or inpatient blind rehabilitation, community blind rehabilitation, or a combination are appropriate venues of care for a specific Veteran.

16. BROS treatment is outlined in this handbook. When the BROS episode of care is completed, the patient is discharged to VIST Coordinator.

17. If outpatient blind rehabilitation (VISOR) clinical services are deemed appropriate, VISOR staff provide O&M, vision rehabilitation therapy, low vision examinations and low vision therapy (including a full spectrum of low vision devices), and computer access training. VISOR provides care for severely disabled Veterans who may travel for some distance and require lodger programs.

18. When the VISOR EOC is completed, the patient is discharged to the VIST Coordinator.

19. BRC programs offer the full spectrum of visual, social, nursing and medical services as well as blind rehabilitation programs that include the greatest breadth and depth of care. Legally blind Veterans with medical co-morbidities are usually best managed in a BRC. Currently, there are thirteen BRCs; services are typically shared between VISNs. When the BRC EOC is completed, the patient is discharged to the VIST Coordinator.