

PRACTICE PERFECT

LOW VISION

Alert Your Low Vision Patients to Assistive Options

BY LINDA ROACH, CONTRIBUTING WRITER

INTERVIEWING SHIRLEY L. ANDERSON, OTR/L, JOSEPH L. FONTENOT, MD, MARY LOU JACKSON, MD, AND LYLAS G. MOGK, MD

Are ophthalmologists missing the opportunity to help low vision patients enjoy a better quality of life? Experts in vision rehabilitation recommend that all Eye M.D.s:

- Be aware that they are the gatekeepers to a better quality of life for people with low vision, a role that requires at least directing them toward resources to optimize their residual vision. Provide (or have staff provide) information—free from the Academy—on how to maintain daily activities, and encourage patients to seek assistance.
- Understand that the earlier patients obtain help, the better their chance of avoiding dependency and depression.

Help is available. “Ophthalmologists need to know that there are many ways to help these patients, and that new techniques and devices are being developed,” said Mary Lou Jackson, MD, director of vision rehabilitation at the Massachusetts Eye & Ear Infirmary. “Comprehensive vision rehabilitation includes patient education and motivation, along with determination and demonstration of training, aids, and devices best suited for each indi-

vidual patient. Each patient’s personal needs and goals should be taken into account. Effective rehabilitation empowers the patient to meet their own personal needs and goals.”

Early intervention is best. “Vision loss challenges people in their daily lives much sooner than you’d think,” said Lylas G. Mogk, MD, director of the Center for Vision Rehabilitation and Research of the Henry Ford Health System in Detroit. “The referral letter says ‘Mr. X was doing fine at 20/80, but his acuity has recently decreased further and now he needs help’—but the patient reports that he has been unable to read for two years. Nobody does fine at 20/80.”

Even a patient with BCVA of 20/40 can benefit from rehabilitation services, especially if a progressive disease is causing the vision loss, said Joseph L. Fontenot, MD, a Mobile, Ala., vision rehabilitation subspecialist who chairs the Academy’s Visual Rehabilitation Committee. Early experience with assistive devices makes it easier to adapt to more severe vision losses later, he explained. “At the early stages, patients can start with some relatively minor adjustments, like using a handheld magnifier or better lighting. Then if their vision gets worse they can just move up the ladder of available options. But if they wait too long, they become dependent on other people and rehab becomes more difficult.”

5 Tips for the Clinician

Low vision subspecialists recommend some do’s and a don’t.

DO:

- Realize the impact of even mild vision loss.
- Recognize the need for early intervention.
- Provide (or have staff provide) education and referral.
- Offer hope, by saying, “We’ve done all we can for now for your eye condition. When we see you again in a year, more possibilities may be available. Meanwhile, our tech will discuss visual rehabilitation with you to help you make the most of your vision.”

DON’T:

- Tell the patient, “There is nothing else we can do.”

A Road Map to Better Care

The Academy’s SmartSight initiative (<http://one.aao.org/smart-sight-low-vision>) and its *Preferred Practice Pattern* for vision rehabilitation (www.aao.org/ppp) agree that although it isn’t necessary for Eye M.D.s to become experts in vision rehab, they do need to take responsibility for completing two initial, crucial steps.

First step: Recognize. If BCVA is worse than 20/40 in the better eye, or if scotoma, field defect, or contrast



Visit www.aao.org/joinaaoe to learn about the many benefits of AAOE membership.

sensitivity loss is present, this should be considered clinically significant because even very early loss of central vision or contrast sensitivity hinders everyday functions.

Second step: Respond. The treating ophthalmologist should ask follow-up questions and reassure patients that there are assistive devices and strategies to help them with day-to-day tasks. Patients should be encouraged to seek out such assistance.

Dr. Mogk suggests asking whether the patient is having trouble reading. “The solution may be simple. The patient might only need a bright, direct light to regain the ability to read, or a high-contrast e-reader for books, but they don’t know that,” she said.

If referral for vision rehabilitation is not an option, the *SmartSight Patient Handout* is a key resource, said Dr. Fontenot.

The SmartSight Patient Handout. The Academy handout can be downloaded for free (<http://one.aaao.org/smart-sight-low-vision>). It explains common types of vision loss; offers reassurance that the impact on daily activities can be minimized; lists resources, including a link to localized help (www.visionaware.org/directory.aspx); and explains how occupational therapy through a rehabilitation program can help people remain active.

Rx: Update Your Clinical Routines
Be alert to performance, not just acuity. Clinicians should always keep in mind that visual function depends on much more than Snellen central visual acuity (VA). Objective measurements demonstrate that 20/20 VA deteriorates significantly in some patients under conditions of low contrast, dim lighting, or glare. Further, patients with good VA may be functionally impaired by scotoma. A rehabilitation team can recommend methods to help ameliorate these situation- and patient-dependent vision problems, Dr. Jackson said.

Delegate. Busy clinicians should consider expanding the role of staff, Dr. Fontenot said. While nurses or technicians interview and prepare the

High-Tech Tools for Low Vision Patients

“It is now easier than ever to help people maintain their visual function. The aids and devices are much cheaper, they’re easier to use, and some of them are accessible in ordinary devices like smartphones and tablet computers,” Dr. Fontenot said.

Mobile solutions. Resource lists in the *SmartSight* handout can help people learn about low-cost visual aids like screen readers, portable magnifiers, and a selection of smartphone apps. For example, Dr. Mogk said, one app uses the phone’s camera lens to “see” paper currency and identify its denomination, either by voice or with large, onscreen text (LookTel Money Reader, \$9.99; Apple devices only).

“E-readers also have made a huge difference,” she said. “You can magnify the print to about three times normal size, or make the letters white on a black background, which is good for anyone with loss of contrast sensitivity.”

At home. Small magnification systems that display reading material on an existing TV or video monitor can be purchased today for a few hundred dollars.

Who pays? Patients usually must pay for assistance devices, because Medicare covers the cost of vision rehab services, but not of equipment.

patient for the physician’s examination, they could identify patients with vision loss, based on criteria set by the physician, and then provide the *SmartSight* handout, he said.

A Broad Solution: Standing Orders

When occupational therapist Shirley L. Anderson, OTR/L, joined the vision rehabilitation team at the Medical University of South Carolina’s Storm Eye Institute, vision rehabilitation referrals usually were not timely. So she spearheaded a hospital-wide effort aimed at expanding the pool of people who can initiate a vision rehabilitation referral. Previously, only one person—the patient’s ophthalmologist—could do this. Now, there is a standing order authorizing any certified and licensed health professional, including social workers and ophthalmic techs, to initiate a referral for a patient who meets specific low vision criteria. The referral request then is sent for sign-off to the treating Eye M.D., who must act on it within 24 hours, Ms. Anderson said.

It worked. “Now we have a waiting list of patients wanting low vision services,” she said.

Help from EHRs? Similarly, electronic health records (EHRs) could be used to ensure that referrals are timely, Dr. Fontenot said. He foresees EHR systems automatically generating the referral paperwork for any patient who meets the specified criteria.

Changing Lives

The number of people with low vision could rise to 80 million by 2050, estimated the Agency for Healthcare Research and Quality in a 2004 report (www.cms.hhs.gov/InfoExchange/Downloads/RTCvisionrehab.pdf).

If Eye M.D.s do not follow *SmartSight*’s advice to “Recognize” and “Respond,” this flood of visually impaired patients might never discover that help is available, Dr. Fontenot said. “We get patients literally every day who say ‘I wish I had known about this earlier.’”

Added Dr. Mogk: “It’s life changing. We get letters that say, ‘You’ve given me my life back.’ And they ask us: ‘Why didn’t my doctor tell me about this sooner?’” ■

Shirley L. Anderson, OTR/L, SCLV, CLVT, is an occupational therapist at the Medical University of South Carolina’s Storm Eye Institute. Financial disclosure: None.

Joseph L. Fontenot, MD, is a Mobile, Ala., vision rehabilitation subspecialist who chairs the Academy’s Visual Rehabilitation Committee. Financial disclosure: None.

Mary Lou Jackson, MD, is director of vision rehabilitation at the Massachusetts Eye & Ear Infirmary of Harvard University, Boston. Financial disclosure: Consults for HumanWare and Visus Technology.

Lylas G. Mogk, MD, is director of the Center for Vision Rehabilitation and Research of the Henry Ford Health System, in Detroit. Financial disclosure: None.