



## AER Vision Rehabilitation Therapy (VRT) Division

<http://vrt.aerbvi.org>

**VRT News**  
**Winter, 2014**

### **Table of contents:**

1. Message from the Chair-Jennifer Ottowitz CVRT
2. Recap of Vision Rehabilitation Therapy (VRT) Week June 23-29 2013- Lenore Dillon CVRT
3. Incorporating Diabetes Health Practices into Routine Instruction- Margaret Cleary MS, RN, CVRT, CHE
4. Help Students Self-Manage Health Practices- Margaret Cleary MS, RN, CVRT, CHE
5. Traumatic Brain Injury (TBI) and Vision Loss-Impressions & Reflections by Ian Shadrack M.A. M.A. CVRT CRC
6. Enrichment Audio Resource Services (E.A.R.S.) for Eyes Inc.-  
Thomas McCarville
7. Mark your Calendars
8. Meet a Member: Jean Qualler
9. VRT Board Contact Information

### **MESSAGE FROM THE CHAIR** **Jennifer Ottowitz CVRT**

On behalf on the officers of the Vision Rehabilitation Therapy Division, I would like to wish you and your family a very happy and healthy new year! We hope that the New Year is full of joy, exciting opportunities and much good fortune!

As the New Year begins, resolutions abound. They may include stopping smoking, to lose weight, to start exercising more, to eat healthier or to better manage finances. No matter what the resolution may be, it begs to answer the question "What will I do differently this year?" This question can apply to your professional as well as personal life. What can I do differently to be more creative when working with clients? What can I do differently to be more efficient with my documentation? What can I do differently to obtain the resources and education I need to help me in my

everyday work? The question can also apply to your involvement in your professional organization. What can I do differently to become more involved with the VRT Division and with AER?

There are plenty of opportunities to become involved with us in 2014. Renewing your AER membership, attending the International AER Conference in San Antonio, participating in a Mangold seminar or other educational offering from AER and reading AER Report and JVIB are just a start. You may wish to write an article for the "VRT News" newsletter or consider becoming involved with one of our Division committees. Soon we will be seeking nominations for officers for the 2014-2016 biennium and will also be seeking nominations for our division awards. We hope you will consider nominating an outstanding colleague for one of these awards and consider running for a leadership position within the Division.

The VRT Division leadership will continue to ask the question "What can we do differently this year to help our members?" as well. We hope to provide a webinar to Division members in the spring/early summer on how to stay updated with ever-changing technology. We look forward to celebrating VRT Week across the world in June (stay tuned to future newsletters and other communications regarding ways you can promote and celebrate all things VRT). We continue to strive to update our website and develop resources to recruit new professionals and we are beginning a joint Task Force with the Mid-America Conference of Rehabilitation Teachers to discuss the planning of a joint VRT themed conference in 2015.

As with any good resolution, initial motivation is not enough to achieve the goal. We must stay active and committed. Every small accomplishment counts in addition to the big ones. We can seek support from each other. We encourage you to contact one of the Division officers with any ideas, suggestions or comments you may have. We want to help you achieve your professional goals and ask that you please help us answer the question "What can we do differently in 2014?"

Sincerely,  
Jennifer Ottowitz, CVRT  
VRT Division Chair

**RECAP of VISION REHABILITATION THERAPY (VRT) WEEK  
JUNE 23-29 2013  
Lenore Dillon CVRT  
Alabama Department of Rehabilitation Services**

Two years ago VRT's met in Boston for a regional AER Conference. Many of the challenges that face our profession were presented and we began the process of responding to the challenges set before us. Recruitment and Retention is one of those challenges to which we hit head on. After we returned from Boston the VRT Recruitment and Retention Committee was formed. Most of the members of the small group assigned to the challenge of Recruitment and Retention are still at work.

The first task of the committee was to establish a VRT Appreciation Week. The last week of June was selected as it coincides with the week of Helen Keller's birthday (June 27<sup>th</sup>). The purpose of VRT Week would be twofold: First, it would be a week concentrated to promoting our profession and attracting potential VRT's. Secondly, it would be a week to encourage and recognize existing VRT's.

VRT Week 2012 started by having each member of the Recruitment and Retention Committee recognize the VRT'S in their home state. A few special luncheons were held and certificates of appreciation were given. The Vision aware ([www.visionaware.org](http://www.visionaware.org)) website paid tribute to VRT's.

In 2013 we built upon the foundation laid last year. Several state agencies and rehabilitation facilities extended some type of recognition to their VRT's. Many individual VRT's promoted the event by conducting presentations designed for recruitment.

Cardelia Cunningham, VRT serving north Alabama used the Helen Keller festival as a mechanism of promoting our profession. Tusculumbia, AL is the birthplace of Helen Keller and the city enjoys a large celebration the last week of June. On Helen Keller birthday, Cardelia conducted a lesson with several students from the Helen Keller School. Each student prepared their own individual birthday cake in the microwave.

Each day of VRT Week, exciting information was posted on the Vision Aware website about the history of our profession. A daily announcement was sent on the VRT listserv encouraging VRT's to read

the website and to respond to the blogs. It was encouraging to learn how many of our colleagues entered the profession.

The end result of VRT Week 2013 is that we still have a long way to go in promoting Vision Rehabilitation Therapy as a profession. Some folks, who are not VRT's, were celebrating the week, while some existing VRT's were still not aware of the event.

The good news is that we took the first step towards promoting our profession. As we tell our learners, baby steps lead to giant steps. It is our desire that VRT Week 2014 will be recognized in each state. We want it to be a week of introduction to our profession. Plans have been started to target awareness to Occupational Therapists and Ophthalmologists.

This article serves as an invitation for VRT's everywhere to join our efforts in planning VRT Week June 22-28 2014. Put your thinking caps on and share your ideas through the VRT listserve, AER VRT Division, or MACRT. We welcome more members on the Recruitment and Retention committee. Please join us as we respond in hope to the challenges set before us. Let's show the world that VRT's make a difference in individual lives and collectively throughout the world.

Please feel free to contact me with any questions or concerns. Lenore

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## **INCORPORATING DIABETES HEALTH PRACTICES INTO ROUTINE INSTRUCTION**

**Margaret E. Cleary, MS, RN, CVTR<sup>®</sup>, CHE,**

It never ceases to amaze me how many different forms of Diabetes Mellitus I have seen in my practice with visually impaired students. Throughout my career, it has been so evident that the disease provides numerous opportunities to incorporate health practices into routine instruction.

The various types of diabetes include:

**Type 1 Diabetes (T1DM)** was formerly known as *juvenile* or *insulin-dependent diabetes mellitus (IDDM)*. The body makes little or no insulin. Treatment requires a regime of insulin injections, meal plan and physical activity.

**Type 2 Diabetes (T2DM)** was formerly known as *adult onset* or *non-insulin-dependent diabetes mellitus (NIDDM)*. The body makes insulin, but it does not work normally. Treatments include meal plan, physical activity, weight reduction and sometimes oral medication and insulin.

**Latent Autoimmune Diabetes in Adults (LADA) or (Type 1.5 Diabetes, T1.5DM)**, names applied to those who are diagnosed with diabetes as adults, but who do not immediately require insulin for treatment, are often not overweight, and have little or no resistance to insulin. When special lab tests are done, they are found to have antibodies that attack their beta cells.

**Gestational diabetes** may turn into T2DM diabetes later in life. Short-term treatment takes place during pregnancy.

**Maturity onset diabetes of the young (MODY)** refers to any of several hereditary forms of diabetes caused by mutations in parental gene disrupting insulin production; often referred to as "monogenic diabetes."

**Other specific types of DM** may be as many as thirty, including congenital diabetes, which is due to genetic defects of insulin secretion; cystic fibrosis-related diabetes; steroid diabetes induced by high doses of glucocorticoids; pancreatic cancer; and accidental destruction of the pancreas.

Treatment in all forms aims to improve glycemic control. Precision timing to balance diet, exercise and insulin is essential in the treatment of T1DM. In T2DM precise times of the recommended plan may not be essential, but a

set schedule helps in achieving optimal results. Vision professionals have great opportunities to assist students in reaching personal goals. No matter what type of diabetes, self-managing practices for our concern include attention to meal plan, exercise, and medication, incorporating safety awareness and optimum health practices.

Some recommendations to students that I incorporate into my instruction opportunities include:

- Schedule your lessons when your energy level is at its best.
- Report recommendations to me made by your medical team.
- Use whatever adaptive communication resources available to learn as much about diabetes as you can.
- Be aware that signs and symptoms may change slowly or abruptly and be ready to recognize and report them.
- Know that a balanced schedule is very important including eating three times a day and, if appropriate, taking a small protein snack before a lesson, between meals and before bedtime.
- Not only eat a balanced meal plan, but include appropriate rest and exercise around lesson times.
- Practice close monitoring of blood glucose and insulin adjustment as activity increases.
- Assume responsibility for carrying simple sugar for potential reactions at all times.
- Recognize that reactions may accelerate during changes of seasons.

- Be aware that the painful neuropathy of the hands or feet may develop into numbness and be prepared to recognize the difference.
- Cope with poor balance by learning how to use a support cane.
- Wear closed-toed footwear both inside and outside to avoid unsuspected foot injury.
- Use principals of anchoring when performing tasks by connecting to somebody or something to provide staying in place and stability.
- Prevent injuring your head when reaching to pick up something on the floor by first anchoring one hand on a stable object.

The following instructions may be helpful for mobility:

- Realize the importance of good foot care with a foot examination and foot wear exploration prior to each lesson.
- Avoid outdoor lessons or exercise during weather extremes.
- During cold weather, use appropriate hand and feet coverings to avoid frostbite; neuropathy produces susceptibility to frostbite unawareness.
- Note that difficulty lifting a foot or stumbling might be indicative of a foot drop; report this to your medical care provider.
- Adjust to arm and hand neuropathy, which decrease the ability to feel the edge of the driveway; try using a roller tip or a pencil tip.
- Take advantage of improved sound awareness on clear days.

I hope these observations will be helpful to you. Have you experienced difficulties or had other ideas while using these suggestions in your student practice? If so, send a letter to the Editor of the VRT Newsletter.

This article is written by Margaret E. Cleary, MS, RN, CVTR<sup>®</sup>, CHE, author and instructor for the Carroll Center's online course: *Diabetes and Visual Impairment: A New View for Vision Professionals and Patients and Families*

<http://carroll.org/online-courses/diabetes-and-visual-impairment-a-new-view-for-professionals>

Margaret received the 2012 AER-VRT Publication Award granted to a member for publications that have benefited and moved forward the field of Vision Rehabilitation Therapy (VRT). Her memberships include AAWB, AER, NEAER, CAER, Division 2 and Division 11, contributing as a presenter, board member, and writer. She states: "I encourage all professionals who feel a particular passion for a subject to commit it to prose. Let others consider if it provides value to their work."

## **HELPING DIABETIC STUDENTS SELF-MANAGE HEALTH PRACTICES**

**Margaret E. Cleary, MS, RN, CVTR<sup>®</sup>, CHE,**

Students involved in rehabilitation for their vision impairment have told me many times they appreciated a wakeup call to look at how they take care of the diabetes causing their vision loss. Often this became an opportunity to turn over a new leaf and renew life energies.

Brian said that he had always been self-managing on the edge. Life kept him too busy to take care of himself. He kidded and joked his way through doctor, diabetes educator and vision rehabilitation therapist visits. Taking time to learn about the newest theories, latest equipment and nonvisual skills resulted in general health improvement. Feeling better made him a believer.

In the field of medicine and health care, self-management means the interventions, training, and skills by which patients with a chronic condition,



disability, or disease can effectively take care of themselves by being taught how to do so. Confidence in the possibility to achieve glycemic control, learn adaptive methods, reach individual treatment goals and continue independence becomes imperative. The “term self-management” refers to the requirements necessary to meet those goals.

The term “self-managing” seems more appropriate for us and the student as the tasks are essentially ongoing and forever. Many challenges affect the ability to perform self-managing tasks. Learning the appropriate means to meet all the objectives of care gives confidence that the ongoing process will meet the basic needs in an achievable manner. The vision rehabilitation therapist plays a pivotal role in helping the student switch from management by others to self-managing.

*Questions the vision rehabilitation therapist may ask the student when evaluating diabetes self-managing challenges:*

- What are your personal goals for being able to self-manage your diabetes?
- What self-managing tasks have been affected by your vision loss?
- Have you noticed any recent emotional feelings caused by the demands of your challenging diabetes care?
- Can you name other factors that add to your stress and how do you relax?
- Who is available to you as a sighted assistant during emergencies and how is that person contacted?
- What changes in your vision throughout the day impact the way you do things?

- How do you monitor and record your own blood glucose level, blood pressure, weight and other signs recommended by your health provider?
- If you use insulin, how do you measure and give it?
- Are you able to list your prescribed medications other than insulin?
- Can you show me how you prepare, organize, adjust, and/or administer your medications?
- What procedure do you follow for your disposal of sharps material?
- Do you insert eye drops or ointment? What technique have you been taught?
- Have you heard about or own any self-managing adaptive devices?
- When did you last meet with a dietitian? What is your meal plan? Do you need meal-planning materials, exchange lists, or recipes in a form you can use?
- What do you do to take care of your feet? Who cuts your toenails? Do you have periodic appointments with a podiatrist? What footwear do you use and when?
- What are your routine daily activities, former exercises and current limitations?
- Do you have an appropriate exercise plan and what safety measures are included?
- What symptoms do you have during low blood sugar reactions? What source of simple sugar do you carry?
- Do you carry medical alert jewelry or an I.D. card?
- How frequently are you ill? Have you and your primary care provider agreed on a plan for sick days?
- Do you have current dated ketone testing equipment?

- Are there other difficult personal management tasks that have been affected and what you have adjusted so far?

Other considerations that the vision rehabilitation therapist may consider after completing a comprehensive assessment:

- The student's functional abilities, vision fluctuations and adaptations already in place;
- The need for other health-related adaptive equipment not indicated above: talking scale, audio blood pressure meter, speech thermometer, audio and tactile aids for insulin pump and peritoneal dialysis equipment;
- Tips for labeling and record keeping;
- Referrals to appropriate professionals in the event of emotional and social needs
- Diabetes education resources in accessible format (books, magazines and videos); and
- Planning for when to utilize family and friends for sighted assistance and for when to seek outside resources.

I hope these observations will be helpful to you. Have you experienced difficulties or had other ideas while using these suggestions in your student practice? If so, send a letter to the Editor of the VRT Newsletter.

### **TRAUMATIC BRAIN INJURY (TBI) and VISION LOSS**

Editor's note, the below article (in quotes) was taken from the internet and then Ian Shadrack added his impressions and reflections on the article.

"Each war leaves its mark on medicine. Amputation was the most common surgery during the American Civil War. World War I brought mustard gas and an epidemic of scarred lungs.

For veterans returning from war in Iraq and Afghanistan, vision problems caused by traumatic brain injury are a growing concern. These veterans have better body armor than soldiers in the past, but they are more likely to be severely shaken by a blast from a homemade explosive device.

About 16% of soldiers who fought in Iraq have returned with vision problems, often due to a traumatic brain injury. In comparison, 9% of Vietnam soldiers and 6% of World War II soldiers had eye injuries.

### **The New Ocular Trauma: Closed-Eye Injuries**

Blunt force can hurt the eye without piercing it. These 'closed-eye injuries' are difficult to diagnose because there's no obvious injury to the outside of the eye. But inside, blunt force can damage the cornea, retina, lens, and optic nerves. Sometimes, vision problems from ocular trauma don't show up for one to three years after the blast. As a result, veterans may not know that they have eye damage until they have an eye exam or start having vision problems after they've left military service.

### **Symptoms of Ocular Trauma**

Blast-related ocular trauma may start as color blindness and become more severe. Other symptoms of vision problems include:

- Light sensitivity
- Eye strain
- Double vision
- Problems with depth perception
- Headaches
- Poor balance
- Dizziness

### **Phantom Vision with Ocular Trauma**

About 20% of people with ocular trauma also have Charles Bonnet syndrome or "phantom vision" in which they see hallucinations. People may be afraid to mention that they see visions, so doctors and family members should ask about them.

Sometimes it can be hard to tell hallucinations apart from what is truly there. These detailed visions can include seeing:

- Strangers or familiar people sitting at home
- Animals in the closet
- Realistic objects that are out of place, such as a double-decker bus
- Strange shapes
- Blurry colors

Visions tend to lessen after a year or 18 months. In the meantime, ant seizure drugs may ease phantom visions for some veterans. If the visions are particularly upsetting, antianxiety medicines may help. Veterans who also have depression may find relief through mental health counseling and medications such as antidepressants.

Other veterans learn eye exercises and other activities to help them ignore the visions. Visions often occur when it is quiet, so staying active, keeping rooms bright, and playing music may help limit visions.

### **Screening for Vision Loss**

A simple eye chart test cannot always diagnose ocular trauma. Veterans may still be able to see well, although they have other visual symptoms. More thorough vision screenings are needed for veterans with traumatic brain injury. All soldiers at Walter Reed Army Medical Center who have had traumatic brain injury within two years now have screenings for vision loss. The Center's staff found that 64% of these soldiers have vision problems.

Other veteran rehabilitation centers are also screening for low vision in soldiers who have had a traumatic brain injury. (Low vision is sight impairment that eyeglasses, contact lenses, surgery, or medicine can't fix.) Tests revealed that these soldiers had mild to severe vision problems. And 2% of them were legally blind.”

### **Impressions and Reflections on above article: Ian Shadrick M.A., M.A., CVRT, CRC**

I believe this article does a nice job of bringing this very real issue of Traumatic Brain Injury (TBI) and subsequent vision loss to the forefront. This is an issue that is facing not only veterans as noted within the article but also many younger adults and children throughout the country for various reasons. We are seeing the largest increase among veterans however, and as pointed out in the article many can go undiagnosed for a

period of time, though the Veterans Administration is making strides in working with returning vets to ensure they are tested for vision loss.

My experience with veterans returning with TBI and related vision loss, which has ranged from varying degrees of low vision to those with total blindness, is that these consumers often experience great frustration as we might expect both because of the TBI and related symptoms but most specifically based on the vision loss. It is important to be mindful of the experience that the consumer is going through as we work with them. One of the most useful tools is to ensure repetition throughout instruction, especially when first introducing a skill, device or set of instructions. Try to utilize concise instructions, and find ways for the consumer to take down information, such as directions, thus allowing them to practice skills or techniques that you are working on. While this seems basic, it can be key in ensuring the use of repetition; and also ensuring that the consumer can practice skills without constant reminders or a VRT present. Another key point to be mindful of is your ability to work with consumer without getting frustrated or upset yourself. This can be challenging as the consumer may not always progress as you might expect, however with continued work and repetition, success is quite possible; it may just be slower than anticipated. Being able to stay calm and work with the consumer again may seem like a very general skill, but it truly can make a significant difference in allowing the consumer to progress and feel as though they are working toward the goal; it also solidifies for the consumer that you working with them and are on their team, thus avoiding the potential for the consumer to shut down or refusing to work on a topic of skill. Often the effects of Charles Bonnet (or similar visions) go untreated due to the perceived stigma associated. It is very important for VRTs to discuss this issue with their veterans or those who may have experienced a TBI. This can often open the door for further discussion as well as any needed treatments for related symptoms. As with all consumers it is important go into the situation with an open mind, but this especially true and helpful when working with persons with TBI.

Ian Shadrack M.A., M.A., CVRT, CRC

Instructor

Missouri State University

## **ENRICHMENT AUDIO RESOURCE SERVICES (E.A.R.S.) for EYES**

### **Thomas McCarville**

The E.A.R.S. for Eyes Program's mission is to provide free blind/low vision rehabilitation training to elderly individuals with vision impairments. The program is a unique and effective approach to blind/low vision rehabilitation training which is able to provide services to many individuals who have not received services in the past. It provides instruction on free self-help audio taped lessons which are used in the home. The process is simple and unintimidating. An individual hears of our program through our community outreach efforts, places a toll free call to our client support telephone center, a telephone interview is conducted by a vision counselor, and appropriate lessons are mailed to the individual, free of charge. The client then receives follow-up telephone support after receipt of lessons. No face-to-face instruction is utilized in our training program, and no designation of legal blindness is required. All of our services are free.

Thomas L. McCarville CVRT

President

Enrichment Audio Resource Services, Inc.

The E.A.R.S. for Eyes Program

800-843-6816.

[www.earsforeyes.org](http://www.earsforeyes.org)

### **MARK YOUR CALENDARS**

I hope everyone will mark your calendars for the upcoming AER International Conference "Moving into the Future" July 30<sup>th</sup>-August 3<sup>rd</sup> in San Antonio Texas. Abstracts are being accepted RIGHT NOW!! So act fast to be a speaker at the upcoming international conference and mark your calendars to attend. See you there!!

### **MEET A MEMBER AER VRT DIVISION: JEAN QUALLER CVRT VA MEDICAL CENTER MILWAUKEE WISCONSIN**

1. How did you enter the Vision Rehabilitation field? I am visually impaired and felt I had a lot to share with others who are facing the same challenges that I have faced. I have personally witnessed the effects on people who do not have the tools to cope with these challenges. I felt a great need to help by honing my

skills through study of the field. I have learned so much more about how to share vital information which can improve the quality of life for anyone facing vision loss challenges.

2. How long have you been Vision Rehabilitation Therapist / vision rehabilitation professional? I graduated with my Masters from Western Michigan University in 2011 and was certified in April of 2012. I currently work in a low vision clinic as a Program Support Assistant (PSA) and not in the capacity of my profession. However, I am providing volunteer assessments to visually impaired citizens which I find very rewarding. Also, I am a member of a group called BOLD which stands for Blind Outdoor Leisure Development. This group is sponsored by the Lions and Lionesses of Southeastern Wisconsin. Through my participation I have been fortunate to interact with many individuals, both sighted and visually impaired, who share my understanding that there should be no barriers to leisure activities to people who have vision loss.
  
3. Tell us about your current job? I am the PSA at the Clement J. Zablocki VA Medical Center in Milwaukee, Wisconsin. I provide administrative assistance to the Visual Impairment Services Team (VIST) Coordinator as well as to the Advanced Low Vision Clinic Specialists. In my capacity as PSA, I have first-hand contact with veterans who have vision loss as I am the person on the other end of the phone contacting the veteran to schedule an appointment in the clinic. I have had many occasions of providing a bit of hope to individuals who have fallen into the circle of hopelessness. I have learned many times over that this little light of hope is all that is needed to change a frown into a smile. I hear it every day. Through the interaction with veterans in my daily job, I have been involved with a group of veterans who saw a need for recreational activities. The Visually Impaired Veterans Activities (VIVA) group was formed. This group started with 2 individuals and an encouraging VIST coordinator along with an energetic PSA. This peer-driven group has grown to 35 members in just one year. This group of veterans has researched, organized, and developed a program that has provided numerous indoor and outdoor activities. This peer-driven group is proof of



the needs, wants, and abilities people with visual impairments, with determination, can develop.

4. Tell us something special about yourself? I am an energetic, self-motivated woman who was a stay-at-home mom with six children (one of who is severely disabled). I faced loss of vision and loss of life as I had known it. I know the challenges of life's struggles and worked hard to earn my undergraduate degree in Business Administration with a minor in Human Resources at the University of Wisconsin, Milwaukee. I went on to earn a Master's Degree in Blind Rehabilitation with a focus on vision rehabilitation therapy at Western Michigan University. This determination is something I frequently share with some who say, "I can't do it". I tell them, "If you want it, you can do it. There is help and there is a professional group of caring people who have devoted their careers to providing that help, through teaching valuable skills to get every person where they want to be in their life.
5. Why did you join the VRT division? I feel this professional organization allows for educational growth and the ability to collaborate with other professionals in my chosen field. Wisdom is gained over time and with the input of many. I learn more and more daily from my colleagues in this profession. These colleagues share my enthusiasm and desire to provide the best quality of life to people who face the many challenges of vision loss.
6. Any words of wisdom for your fellow professionals? In retrospect, I feel multiple certifications are really the best route to follow which would provide a thorough training and an all-encompassing variety of vision therapy tools. Even though I feel certification is a key element in educating the professional, it is equally important to value experience as a tremendous asset to the overall developed professional. I know there are many individuals who need our services and that our profession is one that will continue to grow.

Vision Rehabilitation Therapist Division Board

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Please let me know of any questions, concerns, errors, or comments that you have regarding the VRT newsletter. Thank you to all of the above individuals who submitted content for this newsletter (Jennifer, Lenore, Margaret, Ian, Thomas, Jean) and to Jean Qualler CVRT Milwaukee VA for her work on this newsletter.