

AER Division 7 Newsletter Winter 2018

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Announcements!

AER International Conference – Evolve. Empower. Succeed.

July 25-29, 2018

Reno, Nevada

Twitter Hashtags: #AERIntlConf #Evolve.Empower.Succeed.

Low Vision Rehabilitation Division Awards

Please nominate colleagues and professionals for awards in the Low Vision Rehabilitation Division 7 of AERBVI. Awards will be given in the following four categories, and will be presented at the International Conference 2018 in Reno.

1. Meritorious Award for Outstanding Lifetime Contributions to Low Vision
2. Outstanding Contributions in Direct Services to Individuals with Low Vision
3. Outstanding Contributions to Literature and/or Research in Low Vision
4. Outstanding Contributions to the Low Vision Rehabilitation Division (#7) of AER

Please complete the following questions and email to Dawn Adams dadams8105@me.com by June 1, 2018.

1. Nominee:
2. Award: (Type in the category from the list above):
3. Reason for nomination:
4. Example of nominee's work or contributions:

Low Vision Board of Directors Election

We also are now accepting nominations for the positions of Chair Elect and Secretary/Treasurer.

Chair-Elect

1. Shall serve as a Division Executive Board member
2. Shall chair the Division Program Committee
3. Shall serve as Acting Chair at Division meetings in the absence of the Chair
4. Shall serve on the AER Council of Division Chairpersons

Secretary-Treasurer

1. Shall serve as a Division Executive Board member
2. Shall record the minutes of Division business meetings and prepare them for timely publication in the Division newsletter
3. Shall work with the International Office's financial person to help maintain an accurate record of expenses, income, assets, and financial status of the Division; and shall also maintain a record of receipts and expenses by the Executive Board or its members, by Division Committees or its members, and by Division members expending monies for official Division business.
4. Shall submit a written account to the Division Chair, every 4 months, of all Division receipts and expenses

1. Nominee's name:

2. Reason for nomination:

3. Nominee's biodata:

We encourage you to nominate a colleague or yourself. Please email the following information to Dawn Adams dadams8105@me.com by June 1, 2018.

**CCLVI Scheigert Scholarships
2018-2019**

The Council of Citizens with Low Vision International (CCLVI), an affiliate of the American Council of the Blind, annually awards three scholarships in the amount of \$3,000 each to fulltime college students - an incoming freshman, an undergraduate and a graduate student - all of whom must be low vision, maintain a strong GPA and be involved in school/local community activities.

Application materials must be received by 11:59 pm Eastern Time March 15, 2018. Scholarship monies will be awarded for the 2018-2019 academic year. To access the guidelines, application and vision certification form, visit <http://cclvi.org> and click on [Scheigert Scholarship](#) link.

Applications will be available to complete and submit online from January 1, 2018 to the March 15 deadline. Questions may be directed to scholarship@cclvi.org or 844-460-0625.

We look forward to receiving your application material

Conference in Review

Contributor: Shireen Ali

Vision 2017 – International Low Vision Conference held in The Hague, Netherlands, 25th to 29th June, 2017

Theme: Low Vision Rehabilitation: A Global Right

This conference is a global gathering of experts and people in the field of low vision who work towards preventing avoidable blindness now and beyond 2020. What was most touching for me is to see the effort and resources going into improving services in developing countries. An example of such work is by Dr Karin van Dijk. This Conference and the last one held in Melbourne, Australia in 2014 have inspired me to volunteer rehabilitation services for people with low vision in the South Pacific Islands.

The Conference included high level presentations by experts from various countries on a wide range of topics. Presentations that I attended included topics such as Low Vision and Optical Aids, The changing face of low vision rehabilitation, Brain Plasticity, Reading, Autonomous Cars by Volvo, Eye Tracking, Lighting, Humanoid Robot and much more.

Key Themes:

The future is NOW was loud and clear in my mind as I left the Conference. Following are some of the main themes:

- Making facial expressions and emotions accessible through a prototype belt with webcam and tablet.
- Portable smart devices as vision aids with facial and object recognition features.
- eSight is cutting edge technology which enhances functional vision in real time and video images in colour can be seen with visual clarity. Is this an alternative to eccentric viewing? Read about esight at <https://www.esighteyewear.com/>.
- Quality of life, Reading and Eccentric Viewing
 - Central Vision = Quality of Life. When a person cannot read due to loss of central vision, it affects their quality of life.

- Eccentric viewing techniques using faces, clockface and Amsler Grid may assist some people with reading. Some people have multiple preferred retinal locus (PRL).
 - Active screening is needed to identify vulnerable people who need assistance with reading. i.e. elderly people who see worse than they assume, mentally disabled, rest home residents.
 - Having a high profile patron to promote this work.
 - Digital technology has enhanced reading with research on low vision gaze behaviour and visual accessibility of geometric edges, such as steps and staircases.
 - Special reading glasses to fit over progressive lens for easier reading – MLBINO – cheap simple optics. New improvements include light frame, yellow tint, multi coat flexible and comfortable, stronger lens, single vision lens, MLBINOCA PRO. Wide field compared to magnifiers.
- Brain Plasticity

“When vision is lost, other sensory modalities may take over visual cortex tissue and thus strengthen other senses such as hearing and touch. Recent studies on low vision and brain plasticity are presented in light of their potential for perceptual learning, functional recovery and restoration/rehabilitation”. Residual vision is not black and white but shades of grey. It is not enough to look at the eye. We need to look at the brain too. Plasticity is a source of hope.
 - Lighting, Falls, Reading, Writing

Most falls were in the bathroom, stairs and bedrooms and is worse in people with Glaucoma. More falls occurred at home than away from home. Home was more dangerous perhaps due to poor lighting. Light is the indispensable low vision aid not only for reading but for around the home as well. Lighting assessment in the home is highly recommended. LUX meter us recommended for clinics and bulbs recommended are 6500K, 4500K and 2700K (warm/cool).

Coloured background hues improved perceived acuity over white. Greenish tint on glasses improved acuity over clear glasses. Teach clients to choose their own needs as this is a very subjective area. Preferred writing size correlates with critical print size for reading, or larger. Get closer or write larger.
 - Cerebral Vision Impairment

This may be a world of visual uncertainty for some people. Anxieties, exhaustion, and visual clutter due to too much visual sensory information and field of view is reduced. Individual coping strategies are needed. Hierarchical model of human behaviour suggest that the person sees chaos or selects what they wish to see.

- Psychometrics

In India, the environmental factors affect levels of participation. High attitudinal barrier, parents feeling overburdened, lack of support in schools, unable to use technology for exams, but use of scribes is allowed. However, exam results are based on how well the scribe can write and spell.

- Meet PEPPER– humanoid robot -

<https://www.youtube.com/watch?v=lqlyxg1-gE0>

PEPPER is about four feet tall, looks like a person (except for the wheels where its legs should be), and has more emotional intelligence than your average toddler. It uses facial recognition to pick up on sadness and hostility, voice recognition to hear concern.....and it is actually very good. Over 7,000 PEPPERS greet guests, answer questions and play with kids in Japanese homes.

- Volvo Autonomous Car

Volvo has launched the world's most ambitious autonomous driving trial in Gothenburg, Sweden. (10 Jan 2017).

Volvo is planning to offer customers fully autonomous self driving cars by 2021. As part of a research project called Drive Me, 100 Volvo XC90 equipped with autonomous driving technology will be navigating the roads of Gothenburg, Sweden during 2017 to be tested by ordinary people. Imagine what this means for people who have lost their driving license due to vision impairment!!!!!!

<http://www.volvocars.com/intl/about/our-innovation-brands/intellisafe/autonomous-driving/gallery/autopilot-safety>

Many thanks to **Dr. Karen van Dijk** who has so graciously granted permission for us to share her presentation from Vision 2017.

WHICH MODELS OF LOW VISION SERVICE PROVISION WORK BEST IN LOW-RESOURCE SETTINGS?

Dr Karin van Dijk

Low vision consultant / CBM Global Advisor on Low Vision

Aim of this workshop

Describe promising models of comprehensive service delivery in low-resource settings, including:

- planning and implementation strategies and
- minimum requirements needed to commence or upgrade services.

Underlying philosophy

The provision of low vision care needs to be integrated within eye health services

- early childhood / education services
- community bases inclusive development (e.g. rehabilitation) services
- and it needs to be accessible to all

Comprehensive services (e.g. Education) increase access to inclusive eye health and to support services:

1. Detection + identification Education; Health; Caregivers
2. Clinical low vision assessment Eye health services
3. Getting spectacles, devices Education; Eye Health; Caregivers
4. Assistance in use of 'best' vision Education; Caregivers Eye Health
5. Monitoring / follow-up Education; Eye Health; Caregivers

Who needs low vision services?

Those under the WHO working definition of low vision

- People with other and multiple disabilities (e.g. CVI) -disability inclusive eye health
- Children operated for cataract at young age
- Adults at risk of vision loss: glaucoma, diabetic retinopathy, macular degeneration
- Acuity not only criterion for low vision care!

Opportunities: Inclusive eye health and inclusive education

Every child with low vision or any special needs has a right to

- best possible vision, as young as possible.

- an education comparable to that of peers of
- similar age in their neighborhood

Need for / kind of LV services:

Depends also on access to interventions

- Surgery, especially for children
- Distance spectacles
- Magnifying devices for near vision
- Education at local school

Challenges for successful low vision service delivery

- Eye health, disability, education services, government: access and other priorities
- Comprehensive low vision care does not make a profit – funds are limited or only for eye health
- Limited human resources
- Skills and interest of personnel (ophthalmologists!)
- Time of trained staff
- Time/involvement caregivers
- Community awareness of need for low vision care
- Ensuring clients come to/receive low vision care

Challenges

Network not working well:

- where are the clients?
- who gives training, support after clinical low vision care
- who 'reports' back to eye health-low vision service?
- Access to affordable spectacles, devices, technology
- Follow-up
- Access to appropriate education, employment
- Attitude, beliefs of caregiver

What is needed for successful low vision service delivery

Think of:

- Target group
 - ages children? adults/older people? All? female/male, only low vision / other special needs
 - urban, semi-urban, rural
 - socio-economic status
 - causes of low vision

Think of:

- Organisations of people with disabilities
- Advocacy
- Networking
 - Between services: eye health – education
 - Within service (internal referral)

Think of:

- Management attitude/interest – interest of ophthalmologists
- Profit – non-profit / who pays?
- Government supported service or NGO? Funding
- Government policies, strategies
- Low vision in vision2020 plans
- Health insurance
- Inclusive education

Coordination, networking and management examples:

- Involvement of district services (education and eye care)
- Admission guidelines for children with visual impairment
- Coordination of eye care and education to organize early referral and regular follow-up
- --Access to appropriate, quality education

Think of

- Human resources available
- Skills
- Access to appropriate training
- Time of professionals for quality low vision services
- Time of caregivers

Skills

Example: Refraction

- Is there access to quality (pediatric) refraction?
- Can eye health staff assess and refract young children?
- Can the child / family get the glasses needed in their area?

Think of

- Material resources
 - IAPB essential list
 - Service delivery level
 - Access to and payment of spectacles and low vision devices
 - Access to and use of spectacles, low vision devices
- Making sure a child has an 'early' eye check, refraction
- Refraction and magnification, functional vision

- assessment
- Writing prescription / giving clear information to client/teacher/caregiver
- Obtaining the correct spectacles and devices
 - Training in use
 - Using the spectacles/devices

Think of

- Monitoring of result follow-up
 - caregivers role
- Access to appropriate education
- Livelihood training
- Training in use of devices for work, home....
- EXAMPLE: NGO service vs. eye hospital service

Successful low vision services

- Promote access to inclusive eye health
- Variety of assessment techniques
- Variety of resources, like tests
- Time
- Communication methods
- Assessment area adapted to need of clients
- Networking

Networking teaches eye health that we need more than a pair of spectacles

- Example -People with Intellectual Impairment:
 - Visual problems more common than amongst general population
 - Up to 80% may have poor vision due to uncorrected refractive error
 - Low vision has been reported as 16 -23%
 - >40% has had no previous eye test
 - Those who did access eye health services often told to be 'uncooperative'

Comprehensive low vision services benefit people with Intellectual Impairment

Variety of assessment techniques and resources

- Accessible and low vision friendly working area
- Time
- Attitude of staff and Communication methods

Networking = also referral to livelihood, rehabilitation, education, early childhood intervention services

Comprehensive low vision services can help change policy

1. People with other disabilities accessing low vision-eye health services (example orphanage)
2. Realisation that many children with low vision/with disabilities were in school without having received eye health/low vision services
3. Proposed policy change:
Eye health/low vision care first (Right to 'best' vision), then school placements

Practical ideas to use low vision services
to increase access to inclusive eye health

1. Change 1 or 2 things at a time: working space, time
2. Become creative with the tests you have
3. Ask an organisation of people with disabilities to teach you communication methods
4. Practical ideas to use low vision services to increase access to inclusive eye health
5. Contact programs working with disadvantaged girls and women to 'advertise' your services
6. Network with education authorities
to identify children needing services, and to get financial support for interventions ('spectacles' are cheaper than Braille)
7. Make a plan to substantially increase resources and skills

Successful low vision services

- Target group
- Their caregivers
- Organisations of people with disabilities
- Advocacy
- Networking – within and between services
- Management attitude/interest
- Profit – non-profit
- Government supported service or NGO?
- Funding for comprehensive service

Successful low vision services

- Government policies, strategies
 - Low vision in vision2020 plans
 - Health insurance
 - Inclusive education
 - Admittance policies
- Human resources available
- Skills
- Access to appropriate training
- Time

Successful low vision services

- Material resources
- Access to interventions -Access to and payment of spectacles and low vision devices -technology
- Monitoring of results , follow-up – feedback form eye health to education and vice versa
- Access to appropriate education
- Livelihood training
- Training in use of devices for work, home....

Do we need a 'model' of low vision service provision?

Comprehensive services (e.g. Education)

increase access to inclusive eye health and to support services

1. Detection + identification Education; Health; Caregivers
2. Clinical low vision assessment Eye health services
3. Getting spectacles, devices Education; Eye Health; Caregivers
4. Assistance in use of 'best'vision Education; Caregivers
Eye Health
5. Monitoring / follow-up Education; Eye Health; Caregivers

Stages of a comprehensive low vision service at different service provision levels

- Primary-Community Based
- Secondary
- Tertiary

Mapping and data = Basis for planning services

- Programs providing any kind of low vision care / who could include low vision care in the future
- Quality and quantity of work being implemented
- Skills and abilities of those providing low vision care / low vision trainings
- Effectiveness of the current different low vision trainings
- Material resources available
- Money available

Successful plans

- Common voice
- Use evidence
- Focus on increasing use of services
- Focus on improving efficiency & quality
- Involve good partnerships
- Good leadership
- As program matures, be ready to change the plan

Minimum requirements

- Clients (children, girls/women, other disabilities)
- Interest -advocacy – management
- Principle of 'inclusion' -Start up funds
- Networking – team approach
- Staff: numbers, kind, skills
- Material resources
- Work space (eye health)

Presented by Dr. Karen van Dijk

Special Report from the Field

Report: A VA telehealth initiative in vision rehab.

By Carolyn Ihrig; OD, Chief of VISOR program VAMC Buffalo, NY

The Veteran Health Administration (VHA) Blind Rehabilitation Service has been committed to ensure a Continuum of Care model that extends from the Veteran's home environment to the local Veteran Administration (VA) care site and regionally-based outpatient as well as inpatient blind rehabilitation centers that offer an array of rehabilitation services.

Uncorrectable vision loss due to various ocular conditions restricts travel (especially by automobile) and is one of the barriers to receiving low vision rehabilitation. In 2011, the U.S. Department of Veterans (VA) Blind Rehabilitation Service (BRS) began pursuing innovative care delivery strategies to help Veterans with visual impairment, especially those residing in rural or highly rural areas. The intent was to improve access to low vision/blind rehabilitation care and increase patient satisfaction.

Beginning in November 2012, Low Vision/Blind TeleRehabilitation services were first being offered at the Vision Impairment Services for Outpatient Rehabilitation (VISOR) clinic, Buffalo VA Medical Center, which services several rural sights in western New York. Our goal was to increase access as early as possible after visual impairment diagnosis to help prevent potential decline in functional ability over time. Veterans with Low Vision can be scheduled for face-to-face Low Vision/Blind rehabilitation services at the Buffalo VA, but those Veterans who cannot travel to the Buffalo VA have the option to schedule LV TeleRehabilitation at 3 other VA's and 10 Community Based Outpatient Centers in Western NY. At the end of Fiscal Year 2017, when compared to our face-to-face clinics, 24% more Veterans who would have gone without receiving services, received access to Low Vision/Blind Rehabilitation due to our LV Telehealth clinics. The Veteran's travel distance, time and cost was also reduced.

A few months ago, Matt Hogel, Chief Blind Rehab Services at the VA Caribbean Healthcare System had the foresight to see the potential for adding Low Vision/Blind TeleRehabilitation services at the *Puerto Rico VA*. I'm enjoying working with Matt to help him apply and receive funding for his Telehealth and Vision Rehab project. Increasing access to Low Vision/Blind Rehabilitation services by offering Low Vision TeleRehabilitation is a direct result of Matt Hogel's hard work and dedicated commitment to our Veterans.

I am concurrently working with the Vision Center of Excellence, the Washington DC VISOR clinic and Walter Reed National Military Medical Center. I'm helping the DC VA VISOR clinic set up Low Vision TeleRehabilitation services to share VA Low vision rehabilitation with VA eligible Service Members at Walter Reed National Military

Medical Center. This will be the first VA shared Low Vision/Blind Rehabilitation services to Service Members at a military treatment facility.

The provision of Healthcare is currently changing to include Telehealth services. I am humbled and honored to be working with a growing team that's committed to increasing Low Vision/Blind Rehabilitation access to our partially sighted and legally blind Veterans.