What Can I Do to Help My Patient When I Think There Is Nothing Else I Can Do?
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Never tell a patient there is nothing more to be done. Rehabilitation is always an option.

—Helen Keller

Vision loss is life altering. Ophthalmologists who empathically communicate regarding what their patients are experiencing, that is, effectively communicate not only the cognitive but also the emotional content of their patient’s experience with vision loss, establish better relationships with their patients and facilitate better outcomes for them. Effective communication is critical for patients to understand any likely progression of their vision loss and to provide encouragement that with rehabilitation, many of their lifestyle activities that have been adversely affected by vision loss may again be possible. It is also essential to appreciate and communicate an understanding of the psychologic and physical impact of vision loss.

Even the earliest stages of vision loss harbinger significant changes in everyday activities … and may also affect self-esteem and independence… the uncertainty of further loss of vision often creates at least as much disruption in psychological well-being as the initial diagnosis.1

In the United States, legal blindness is defined as 20/200 or less in the better-seeing eye with best correction or maximum visual field diameter of 20 degrees or less in the eye with the widest visual field. Likewise, other classifications of vision loss are based on acuity loss or reduction in visual fields. Low vision in the US population generally is defined as best-corrected vision of 20/40 or worse. Worldwide, definitions of vision loss and availability of services vary. However, vision of even better than 20/40 may affect an individual’s functional vision because contrast sensitivity loss, scotomas, color blindness, anisometropia, and other conditions may significantly alter visual perception.

The most important criterion in determining the need for vision rehabilitation is how loss of vision compromises everyday activities and functioning. It is not necessary to reach a particular clinical value or other criteria to justify a referral for a low vision examination or vision rehabilitation. An estimated 90% of individuals with vision loss that cannot be corrected by refraction or medical or surgical therapy, that is, low vision, have useful residual vision and would likely benefit from vision rehabilitation.2-3 Rehabilitation for patients with low vision, with more profound vision loss, or who are blind may differ in specific techniques but not in the approach or intent; the goal is to maximize functional status.

Decreased vision is associated with reduced emotional, physical, and social functioning,4 and with lower levels of physical activity, which contribute to increased risk of obesity, chronic obstructive pulmonary disease, arthritis, stroke, and congestive heart failure.1 Everyday activities and social functioning can be affected by even relatively modest vision loss. Use of community services has been found to increase by 12% for each line of vision lost,1 and an increased risk of falls and hip fractures has been reported with moderate vision loss.7 As much as 39% of legally blind individuals have limitations in activities of daily living, compared with 7% of those with better vision.8 Onset of legal blindness results in a 78% increased risk of limitations in Instrumental Activities of Daily Living7 that underpin an independent lifestyle. With glaucoma, for example, decrements in quality of life begin with the onset of vision loss and decline sharply as visual fields decrease.10 The impact of vision loss is comparable to the psychologic impact and changes in lifestyle caused by major medical conditions.11 Particularly noteworthy is a doubling in mortality due to moderate visual loss.12

Depression is a significant comorbidity of vision loss. Self-reported vision loss, that is, the patient’s own report of their loss of visual function, results in an increased incidence of depression, whereas clinical measures of visual acuity do not.13 This underscores the need to appreciate what the patient is experiencing to effectively address the impact of their vision loss. Declining vision is a harbinger of an increased fear of falls and possibly falls themselves, as well as restrictions on traveling independently and other activities. Understanding the impact of vision loss should catalyze referral for vision rehabilitation. Quality of life, that is, outcomes that are significant to individual patients, is the ultimate patient-centered goal. Although high-contrast visual acuity remains the universal clinical benchmark for visual performance, outcomes such as improving visual acuity by 2 lines, 8 letters, or other clinical criteria are neither adequate nor sufficient to enhance quality of life, unless they address the patient’s expressed needs. Moreover, aspects of vision function that are measured less routinely, such as contrast sensitivity, may have greater effect on everyday functioning than high-contrast visual acuity loss. Although patient satisfaction with his/her ophthalmic care is not guaranteed by improvement in a clinical measure, their satisfaction often can be improved greatly by vision rehabilitation that addresses functional vision and that will permit patients to resume personally meaningful activities.

Vision rehabilitation begins with vision evaluation, testing, and prescription of devices to enhance residual vision and performance, followed by training, environmental modifications, and other techniques to enhance functioning. Without a thorough evaluation of functional
vision, the potential for effective rehabilitation is unknown; for that reason alone, referral to a low vision specialist, either an ophthalmologist or an optometrist with specialization, for a comprehensive evaluation and assessment is warranted. Once vision has been optimized, providers from rehabilitation specialties such as occupational and physical therapists or orientation and mobility instructors, vision rehabilitation teachers, activities of daily living instructors, and others can help patients maximize their ability to function with vision loss.

Talk candidly with patients about their goals and the opportunities for vision rehabilitation. Unfortunately, a thorough discussion about rehabilitation, available services, alternatives, and similar issues requires significant time; for most ophthalmologists, other than those who provide vision rehabilitation directly, this would require substantial modification of practice patterns. One alternative would be to incorporate professionals, such as social workers, psychologists, or others, into a practice regularly to permit patients to receive therapeutic communication and interventions that address their needs. Listening to patients and addressing his or her concerns can provide hope, essential to the rehabilitation process, as well as directly help patients achieve their rehabilitation goals. Hearing from others experiencing similar issues is itself often therapeutic. Professionally led groups for newly diagnosed patients, diabetes self-management (ideally led by certified diabetes educators), and other topics of common concern and interest can provide a feeling of community and are an efficient way to impart information and support patients. These professionals generally are able to receive third-party reimbursement for their time spent to address issues related to vision loss.

Reimbursement for services is a common concern of professionals. Since May of 2002, Medicare beneficiaries with visual acuity of less than 20/60 after correction of refractive error or who have central scotomas, generalized visual field contraction or constriction, or homonymous or heteronymous bilateral field defects are eligible for Medicare coverage for vision rehabilitation services. These services must be physician prescribed and designed to improve functioning. Approved services include those designed to address activities of daily living and self-care and home management skills designed to improve independence and safety. Other activities within the scope of the Program Memorandum (and therefore, eligible for reimbursement) include medication identification and management, cognitive skills training, monitoring of blood pressure, reading care instructions such as post-discharge materials, gait training, and safe meal preparation when provided by Medicare-approved professionals, that is, occupational or physical therapists. Many third-party payers follow the Medicare guidelines with regard to vision rehabilitation services. Medicare, and most third-party payers, does not cover vision-assistive equipment or services provided by orientation and mobility instructors, vision rehabilitation teachers, activities of daily living instructors, or other professionals not included in the Program Memorandum. State vocational rehabilitation agencies may be a resource for obtaining these devices or services, but eligibility and coverage vary from state to state. In addition, community-based organizations, as well as many optometric practices, provide vision rehabilitation services. A comprehensive directory of these resources is currently being developed by Lighthouse Guild, a New York–based organization, and is expected to be available by year end.

Linking treatment success to achieving a patient’s goals addresses the impact of vision loss, facilitates patient engagement, and creates opportunities for shared decision-making. This reinforces the focus on patient goals, underscores patient engagement as integral to patient-centered care and fundamental to the rehabilitation process. Ignoring a patient’s perceptions contributes to excess morbidity. Although the level of vision loss that adversely affects task performance and quality of life has not been established, it is task and patient dependent.

Because vision loss may be progressive, its impact on functional abilities can intensify, and the usefulness and success of unmodified rehabilitation strategies may be impeded. Assessment, reassessment, and modification of treatment plans are necessary for vision rehabilitation to remain effective and relevant. Furthermore, as vision loss frequently increases with age, so too does the development of other health conditions that affect overall quality of life and affect vision rehabilitation. For example, tremor with Parkinson’s disease may alter choice of vision-assistive equipment, such as using a standing video magnifier rather than a handheld one, or modification of protocols, such as using cuff weights to reduce tremor amplitude and permit use of a handheld video magnifier. To help articulate basic concepts of vision rehabilitation, a 10-module self-paced e-learning course from Lighthouse Guild that provides a basic understanding of vision loss and the vision rehabilitation process and an American Academy of Ophthalmology video, “There is Something Else You Can Do,” are available on the American Academy of Ophthalmology website.

One of the things that we can do as ophthalmologists is to realize the importance of referral for vision rehabilitation for any patient who is starting to lose their vision … Vision rehabilitation is now the standard of care.

—David W. Parke II, MD

References


Footnotes and Financial Disclosures

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