

LOW VISION SPECIALTY CERTIFICATION Occupational Therapist

Table of Contents: **Activity Evidence Form EXAMPLES**

- Below is one example for each type of **form**, not for each criterion. The examples are to help you understand how to *complete* each form, regardless of the criterion.
- The forms that are included are [hyperlinked](#) in the table of contents below.
- Please note that these are *examples only* to help guide you in the type of information to include. For many reflections, your style may be different; for example, more narrative or more bulleted.
- Note that unused forms (pages) are not included in this document. Please do the same with the final set of evidence forms you submit with your application.

Criterion 1: Knowledge: Diagnostic Considerations

- Expert Witness
- Formal Learning– Minimum 10 contact hours needed
- Independent Learning–Minimum 10 contact hours needed
- Publication – Peer-Reviewed

Criterion 2: Knowledge: Evaluation

- [Expert Witness](#)
- Formal Learning–Minimum 10 contact hours needed
- [Independent Learning](#)–Minimum 10 contact hours needed
- Publication – Peer-Reviewed

Criterion 3: Knowledge: Intervention

- Expert Witness
- Formal Learning–Minimum 10 contact hours needed
- Independent Learning–Minimum 10 contact hours needed
- [Publication – Peer-Reviewed](#)

Criterion 4: Knowledge: Regulation & Payers

- Expert Witness
- [Formal Learning](#)–Minimum 3 contact hours needed
- Independent Learning–Minimum 3 contact hours needed
- Publication – Peer-Reviewed

Criterion 5: Evaluation: Performance Skills

- Client-Based Case Study
- Mentee (does not include supervisory relationship)
- [Self-Analysis of Video Recording](#)

Criterion 6: Evaluation: Critical Reasoning

- [Critical Reasoning Scenarios](#) (2)
 - List of Assessments for CR Scenarios
- Formal Specialized Consultation for Evaluation
- Program Development
- Research

Criterion 7: Intervention: Performance Skills

- [Client-Based Case Study](#)
- [Mentee](#) (does not include supervisory relationship)
- Self-Analysis of Video Recording

Criterion 8: Intervention: Critical Reasoning

- Client-Based Case Study
- [Formal Specialized Consultation for Intervention](#)
- Mentee (does not include supervisory relationship)
- [Program Development](#)
- [Research](#)

Criterion 9: Psychosocial Critical Reasoning

- Client-Based Case Study
- Formal Specialized Consultation for Psychosocial
- Mentee (does not include supervisory relationship)
- Program Development
- Research

Criterion 10: [Ethical Practice](#) – The 3 ethical practice scenarios are found within the application itself.

Criterion 11: Establishes Networks

- Formal Specialized Consultation
- [Marketing Activities](#)
- [Presentation](#)
- Volunteer Leadership

Criterion 12: Advocating for Change

- [Advocacy Efforts](#)
- [Advocacy Case Study](#)
- Presentation
- [Public Awareness Efforts](#)
- [Volunteer Leadership](#)

EXPERT WITNESS/TESTIMONY[Back to Criteria](#)**Criterion 2—Knowledge: Evaluation****Demonstrates knowledge of relevant evidence specific to *evaluation* in low vision.****Guidelines**

- Serving as an expert witness in a civil or criminal legal case court or in arbitration.
- Providing expert testimony in official hearings at the local, state, or national level.

1. Describe the expertise which you were able to share relevant to low vision. (*average word guideline—200*)

I provided expert testimony for Mr. P, age 45 years, who worked in a chemical plant and sustained burns on the job when a faulty valve resulted in a toxic chemical being sprayed in his face and eyes. The accident caused total vision loss in his right eye and 20/400 visual acuity in his left eye.

Mr. P sued the company for negligence; his attorney contacted me to testify about his functional vision status and the impact of his vision loss on self-care, home management, community mobility, ability to work, and quality of life.

As an OT with a Graduate Certificate in Low Vision Rehabilitation, 8 years' experience with the low vision population, and several publications, I was considered qualified to provide testimony. I summarized Mr. P's OT low vision evaluation findings and provided specifics about how his injury significantly affected his ability to participate in ADLs and work. Key elements of the testimony focused on his limitations in reading, inability to drive, ability to perform current job demands, and potentially reduced vocational opportunities. In addition, I briefly summarized research on impact of vision loss on driving, reading, and work, as well as psychosocial impact of vision loss.

2. Describe how the knowledge acquired from this activity "*demonstrates knowledge of relevant evidence specific to evaluation in low vision.*" How did the activity influence the way you practice, or how did it affect your client outcomes? (*average word guideline—200*)

The role of expert witness has influenced how I provide low vision rehabilitation services. After this experience, I expanded my use of standardized and objective assessments to include evaluations that helped me understand the psychosocial impact of vision loss. I have begun to consistently include the Beck Depression Inventory (Beck, Steer, & Brown, 1996) in my initial evaluation of clients. I am also more careful to ensure that my documentation is thorough and up to date. I was called as an expert witness 8 months after working with Mr. P and was fortunate that I had sufficiently clear evaluation summaries and treatment notes to share during testimony. However, one change in documentation that I have made because of this experience was to record my clinical observations more explicitly, because standardized assessments do not always capture all relevant information.

The experience increased my awareness of the importance of evidence-based practice, which involves not only staying abreast of the latest research in low vision rehabilitation but also contributing to research as a practitioner. This experience validated my decision to pursue a specialty certification in low vision and to seek opportunities to contribute to the body of knowledge in low vision rehabilitation research.

3. **Submit verification of activity** as a separate attachment. May include any 1 of the following:
 - Transcript of the testimony.
 - Notice of deposition.
 - Letter from the attorney.

For this example, verification is not included but should accompany this activity if submitted.

INDEPENDENT LEARNING[Back to Criteria](#)**Criterion 2**—Knowledge: Evaluation**Demonstrates knowledge of relevant evidence specific to *evaluation* in low vision.****Guidelines**

- **Minimum of 10 contact hours** required.
- Multiple activities may be used to meet the hour requirement for the criterion.
- Learning must have occurred in the past 5 years.

Please identify the type of independent learning activity in which you participated:

- Independent reading from AOTA-Approved Independent Learning List in low vision.
- Independent reading of recent peer-reviewed, professional articles, or chapters in textbook not associated with a formal learning course.
- Independent review of professional electronic resources (e.g., NIH, CDC, CanChild).
- [AOTA Journal Club Tool Kit](#) (reading & discussion time). *Must be AOTA member to access the kit.*
- AOTA Critically Appraised Paper (CAP, includes submission to the [AOTA Evidence Exchange](#)).

1. Why did you choose this activity?

- Clinical reference for specific population, program, or individual
- Invited peer review of scholarly work or publication (print or online)
- Preparation for poster or presentation
- Preparation for academic lecture
- Literature review for research project
- Preparation for serving as a mentor
- Other, please specify: Preparation for discussion through a Low Vision Occupational Therapy online monthly journal club

2. Bibliography of select item(s) used for independent learning. *List in APA format.*

Barstow, B.A., Bennett, D.K. & Vogtle, L.K. (2011). Perspectives on home safety: Do home safety assessments address the concerns of clients with vision loss? *American Journal of Occupational Therapy*, 65, 635-642.

Janes, William E., & Metzger, Lizabeth. (2011). AOTA Journal Club Toolkit. Retrieved 12/7/XX, from http://www.aota.org/documentvault/ebp/journal-club-toolkit_1/journal-club-toolkit.aspx?ft=.pdf

Kerr N.M., Chew S.S., Eady E.K., Gamble G.D., & Danesh-Meyer H.V. (2010). Diagnostic accuracy of confrontation visual field tests. *Neurology*, 74 (15), 1184-1190.

Menozi, M., Baumer-Bergande, E., & Seiffert, B. (2012). Working towards a test for screening visual skills in a complex visual environment. *Ergonomics*, 55 (11), 1331-1339.

Orr, P., Rentz, A. M., Margolis, M. K., Revicki, D. A., Dolan, C. M., Colman, S., Fine, J. T., & Bressler, N. M. (2011). Validation of the National Eye Institute Visual Function Questionnaire-25 (NEI VFQ-25) in age related macular degeneration. *Investigative Ophthalmology & Visual Science*, 52, 6, 3354-3359.

Patel, P.J., Chen, F.K., DaCruz, L., Rubin, G.S., & Tufail, A. (2011). Test-retest variability of reading performance metrics using MNRead in patients with age-related macular degeneration. *Investigative Ophthalmology & Visual Science*, Vol. 52, 6, 3854-3859.

Rabin, J., Gooch, J., Ivan, D., Harvey, R., Aaron, M. (2011). Beyond 20/20: New clinical methods to quantify vision performance. *Military Medicine*, 176, 3, 324-326.

Swamy, B., Cumming, R. G., Ivers, R., Clemson, L., Cullen, J., Hayes, M. F., Tanzer, M., & Mitchell, P. (2009). Vision screening for frail older people: a randomized trial. *British Journal of Ophthalmology*, 93, 736-741.

Tabrett, D.K. & Latham, K. (2011). Factors influencing self-reported vision related activity limitations in the visually impaired. *Investigative Ophthalmology & Visual Science*, 52, 8, 5293-5302.

Trauzettel-Klosinski, S., Dietz, K., & the IReST Study Group. (2012). Standardized assessment of reading performance: The New International Reading Speed Texts IReST. *Investigative Ophthalmology & Visual Science*, 53, 9, 5452-5461.

Wei, H., Sawchyn, A. K., Myers, J. S., Katz, L. J., Moster, M. R., Wizov, S. S., Steele, M., Lo, D., & Spaeth, G. L. (2012). A clinical method to assess the effect of visual loss on the ability to perform activities of daily living. *British Journal of Ophthalmology*, 96, 735-741.

3. Date(s) of independent learning

Second Monday of every month, January – November, 20XX.

4. Time spent engaged in independent learning.

- For reading, estimate 8–12 published pages/hour. *Not required for AOTA-identified independent learning list of resources.*
- For journal club, discussion time counts toward 10-hour requirement.

Toolkit – 41 pages: 2.75 hours

Articles – 78 pages: 5.25 hours

Journal club participation (facilitator) – 11 meetings @ 90 minutes = 16.5 hours

5. Describe the relevance of the independent learning activity to your practice in low vision. (*average word guideline–200*)

As a solo practitioner, I felt the need to establish connections and ongoing interactions with other OTs providing low vision rehabilitation in order to ensure my continuing competence and awareness of current evidence. I felt that a journal club would give me the opportunity for ongoing dialog with other practitioners and provide an intellectually challenging and stimulating venue for appraising and keeping abreast of new developments in low vision.

Preparation for leading the meetings would challenge me to critically examine articles to determine their relevance for discussion by the group. The AOTA Journal Club Toolkit provided a format for critically appraising each article and guiding meaningful discussion during the meeting.

The group chose evaluation as the first area of discussion because of the increasing Medicare emphasis on using standardized assessment to justify intervention and measure client outcomes. The group met monthly using an online platform that allowed members to see and interact with one another. We examined 11 articles that addressed various aspects of evaluation and reviewed well-established and new assessments.

6. Describe how the knowledge acquired from this activity “demonstrates knowledge of relevant evidence specific to evaluation in low vision.” How did the activity influence the way you practice, or how did it affect your client outcomes? *(average word guideline–200)*

Participation in the journal club increased my knowledge of assessments available to me in practice. I learned about new assessments such as the IReST (article #10) that were developed after I completed my formal low vision rehabilitation education. I also learned more about the psychometric properties and utility of commonly used assessments such as the MNread (article #6).

By critically appraising the research on the instruments, I gained a better understanding of the strengths and limitations of each to guide me in development of the intervention plan. The knowledge I acquired about the data that was generated by each assessment helped me develop a more critical eye when selecting assessments and interpreting results, and I have more confidence in my selection of relevant assessments that will help me develop appropriate intervention plans.

My increased understanding of what a test is measuring has also improved my ability to document the results in a way that provides a stronger justification for OT services to physicians and other stakeholders, and I write more objective and measurable goals. This increased confidence has also enabled me to speak with greater authority to physicians and other referral sources and increased referrals to my practice.

PUBLICATION – PEER-REVIEWED[Back to Criteria](#)**Criterion 3—Knowledge: Intervention****Demonstrates knowledge of relevant evidence specific to *intervention* in low vision.****Guidelines**

- Examples of peer-reviewed publication include journals such as *AJOT* or *OTJR*.
- May include a chapter in an occupational therapy or related professional textbook, if chapter has gone through *peer review* (a process in which subject matter experts, using a formal system and defined guidelines, provide content guidance to an author and recommend publication, revision, or rejection of a work).

1. Submit APA reference for the publication. For in-press publication, also include a verification letter or e-mail identifying applicant and anticipated date of publication.

Smith, A., Jones, B., & Brown, C. (20XX). The impact of lighting modifications on daily activities in older adults with low vision. *American Journal of Occupational Therapy*, XX(X), XXX–XXX. <http://dx.doi.org/XXX>

2. If applicant is not identified as first or second author, please describe your contribution/involvement in the development of the publication. *(average word guideline–200)*

Applicant is first author.

3. Provide a reflection indicating why this publication was chosen to represent “*knowledge of relevant evidence specific to intervention in low vision*.” *(average word guideline–200)*

As I reflect on my experience completing the project that led to this publication, it is clear that my knowledge of planning lighting modifications for people with vision loss has greatly expanded. I have gained an appreciation for the importance of using a comprehensive, objective lighting assessment to plan lighting interventions as well as the importance of fully involving the client in the process. Our participants were intrigued and motivated by the objective nature of the light meter reading and other portions of the lighting assessment. The process seemed to promote readiness for changes in their lighting. I learned that a lighting intervention must address more than the addition of a task lamp or higher wattage bulb. Positioning the client, reading material, and light source are key intervention components. The influence of glare and outdoor lighting must also be addressed. One of the most important lessons I learned was that clients benefit from comparing and contrasting lighting options in the context of doing tasks relevant to them.

FORMAL LEARNING[Back to Criteria](#)**Criterion 4—Knowledge: Regulation & Payers****Demonstrates knowledge of laws and regulations relevant to low vision, including payer sources.****Guidelines**

- **Minimum of 10 contact hours** required.
- Multiple activities may be used to meet the hour requirement for the criterion.
- Learning must have occurred in the past 5 years.

Please identify the type of activity in which you participated:

- AOTA CE: Participation in Self-Paced Clinical Course or CE Product from the list of AOTA offerings approved for this certification. *Completion of course will be verified by AOTA. Submission of additional documentation beyond this form not required.*
- Non-AOTA CE: Attending workshops, seminars, lectures, or professional conferences with formal established objectives.

Participation in post-professional academic coursework. *Attach unofficial transcript.*

1. Activity information.

Activity Title	University XYZ–Foundations in Low Vision IV
Provider/Instructor	Jane Doe, PhD, OTR/L, SCLV
Activity Date(s)	06/10/XX to 08/30/XX
No. of Contact Hours	3 College Credit hours--45 contact hours

2. Activity Learning Objectives. *List up to 5.*

A)	The course had multiple objectives; however, the one specific to this criterion was "Demonstrate knowledge of the ethical, legal, and fiscal regulations in provision of low vision rehabilitation."
B)	
C)	
D)	
E)	

3. Describe the relevance of the activity to your practice in low vision. *(average word guideline–200)*

I have a private practice in low vision and bill for my own services. It is imperative that I know the Medicare rules and regulations for billing to remain financially solvent. This course included 4 hours of instruction on Medicare rules and regulations for low vision services. The instructor discussed the Medicare memorandum that established coverage of low vision rehabilitation in 2002; the ICD–9 codes that support medical necessity for low vision services and the appropriate CPT codes for billing, including codes for neurological conditions; the role of the fiscal intermediary and limited coverage determination; and other referral and reimbursement sources for low vision rehabilitation, including private insurance companies, Medicaid, state vocational rehabilitation, and health maintenance organizations. We discussed documentation guidelines and requirements for service provision in a clinic versus the client's home and participated in a practicum on how to correctly word goals. We also discussed issues unique to low vision programs, including whether to loan optical devices and how to help clients purchase expensive assistive technology like CCTVs. The final lecture focused on resources for low vision professionals for networking, advocacy, and continuing education to stay current on billing and payer source changes.

4. Describe how the knowledge acquired from this activity *"demonstrates knowledge of laws and regulations relevant to low vision, including payer sources."* How did the activity influence the way you practice, or how did it affect your client outcomes? *(average word guideline–200)*

This course increased my knowledge and awareness of the importance of reviewing the AOTA and state OT Web sites for changes or issues that affect OT services and reimbursement. I now review these sites weekly. I also learned to carefully review information from my Medicare fiscal intermediary to appropriately bill for specific situations and how to navigate the Medicare Web site to locate information on OT coverage and billing. I now ensure that the medical diagnosis from the referral source matches the correct ICD–9 code and procedural codes for accurate billing.

I also learned the importance of establishing a good working relationship with my referral sources to ensure that I receive complete and accurate referral information necessary for documentation and as well as appropriate and timely referrals. Using the knowledge gained from this course, I revised my referral forms to make them more complete and also less time consuming to complete.

Finally, the course prompted me to network with other low vision providers on reimbursement issues, funding for devices, and documentation regulations. Through this networking I was able to establish an agreement with a vendor that my clients could trial the use of an expensive device prior to purchase.

5. **Submit** documentation that verifies completion of the activity, such as certificate of completion or unofficial transcript. *Not required for AOTA courses.*

See attached transcript from XYZ University, Anytown, USA. For this example, verification is not included but should accompany this activity if submitted.

SELF-ANALYSIS OF VIDEO RECORDING[Back to Criteria](#)**Criterion 5—Evaluation: Performance Skills****Administers standardized assessments specific to low vision, consistently integrating clinical observations throughout the evaluation process.****Guidelines**

- Submission of actual video recording is **not** required for application; however, appropriate permissions should be obtained by applicant whenever engaging a client in a video-taped session.

1.

Age of Client	71 years old
Client Diagnosis(es)	Male
Setting for Evaluation	Age-Related Macular Degeneration
Date of Video Recording	November 19, 20XX

2. Provide a brief summary of the video contents and how it demonstrates your ability to “administer standardized assessments specific to low vision, consistently integrating clinical observations throughout the evaluation process.” *(average word guideline–200)*

In the video, I assess the reading ability of my client using the Pepper Visual Skills for Reading Test, a standardized assessment for measuring the reading performance for people with central vision loss due to macular disease. The video demonstrates how I gathered required materials and explain the purpose of the test and procedures to the client. In the middle of the process, the client informs me that he no longer reads because he “can’t see” and the glasses the doctor prescribed “are no good.” I ask the client if he is willing to continue with the assessment, and he agrees. Shortly thereafter, he becomes agitated when he is unable to read the letters and words. He makes disparaging comments about “reading like a second grader” and states “the doctor said there wasn’t more they could do.” Although the client was technically not at a stopping point per standard assessment procedures, my clinical observations indicated that the reading test should be terminated. Given the pattern of errors, I suspected that his inability to compensate for his central scotoma prevented him from reading effectively and efficiently.

3. After reviewing this video, describe the insights you gained, and reflect on how the analysis experience validated or supported change in your practice related to evaluation. *(average word guideline—400)*

After I reviewed the video, I realized that I need to change my evaluation approach by de-emphasizing the need to complete the assessments, and instead, focus more on establishing rapport, reflect on clinical observations, and actively listen. A description of the specific insights I learned include:

- My discomfort with the client's complaints resulted in behaviors that made me appear nervous. This was not evident to me at the time of the assessment, but was apparent in the video.
- I falsely assumed that the client's complaints were an indication that he did not want to participate in our session; however, careful review of the video shows that the patient's complaints indicated he truly did not understand that there was hope for his situation. Up to this point, all he heard from his doctor was that not much could be done. I did not focus on this concern or clarify that, while the doctor may not have any medical solutions to offer, there are ways to compensate for his vision loss.
- My emphasis on quickly completing the reading assessment caused me to miss some crucial clinical observations. I missed that the patient was not reading at the recommended reading distance for his bifocals. The low vision optometrist prescribed +400 reading bifocals and recommended a reading distance of 10". I knew this but did not fully attend to his reading distance during the assessment. In addition, I did not notice that the client intermittently closed his right eye while reading. This had a direct impact on his reading efficiency. I could have intervened to alleviate this problem.
- I forgot to turn on the task lamp. Use of task lighting could have increased his success with the reading assessment. Although use of a task lamp is not part of the assessment protocol, the positive effects of task lighting on reading is well- established in literature.

Through this self-analysis activity, I learned that I need to avoid getting too caught up in completing the reading assessment. I need to first put clients at ease, focus on their needs, and show empathy towards their concerns. In addition, I need to educate clients about the reasons they are experiencing problems and explain strategies that can allow them to resume valued activities.

CRITICAL REASONING SCENARIOS[Back to Criteria](#)**Criterion 6**—Evaluation: Critical Reasoning**Synthesizes and interprets assessment data and clinical observations related to the client, context, and performance in low vision.****Guidelines**

- Applicant chooses **2** assessments and completes this 2-part form relative to the application of each assessment tool with a client. Selected tools can either have been used with the same client or different clients.
- Assessment tools may be identified from the [list](#), or applicants may submit an assessment that is not listed.
- For each assessment, answer the following questions by reflecting upon a case from your practice. You may choose to use different cases for each assessment tool.

Part I**ASSESSMENT 1** (Part 1 of 2)

1. Name of assessment.

MNread acuity test chart

2. Describe the client, client factors, and case contexts that contributed to your selection of the assessment for the identified case.

REFERRING DIAGNOSIS

23 year old male with a left homonymous hemianopsia (HH) from a closed head injury 3 months prior. The ophthalmologist referred him to address difficulty reading. The referral included the following information: 1) permanent and complete HH of occipital origin, 2) no visual pathology other than the HH, 3) 20/15 distance Snellen acuity.

CLIENT FACTORS

The client was unconscious for 36 hours following the injury. He experienced mild left hemiparesis that had completely resolved and a significant whiplash injury. He reported the following reading difficulties: 1) missing the beginning letters in words, 2) difficulty locating the next line of print, 3) slow reading speed, 4) required significant concentration to see words clearly, 5) visual blur after reading 3-5 minutes with occasional disappearance of letters on the page after 60 seconds, 6) onset of a severe frontal headache for several hours after 10 minutes of reading.

CASE CONTEXT

The client was a full-time graduate student. He expressed a strong desire to improve his reading performance so he could return to school and finish his degree.

3. What considerations regarding reliability, validity, relevance, and currency did you consider when selecting this assessment?

RELIABILITY

MNread is a clinical and research instrument with well-established reliability and validity (Legge, 2007).

RELEVANCE

The test quickly measures 3 aspects of reading performance critical for someone required to complete significant amounts of reading. These include maximum reading speed, critical print size and reading acuity. I selected the chart because it would determine 1) if the client had sufficient reading speed to meet the reading demands of graduate school, 2) if a large print format was needed for best reading performance, 3) if his reading acuity was lower than distance acuity - a finding that might suggest a focusing deficiency.

CURRENCY

The test is included on the relevant assessments list.

4. Describe the assessment results, including those gathered through clinical observation, and what these results told you about the client's occupational performance.

ASSESSMENT RESULTS

MNread results showed a maximum reading speed of 65 words per minute; a reading acuity of 20/50, and critical print size of 2.5M which was 2.5x larger than his reading acuity.

PERTINENT TEST OBSERVATIONS

1) slow reading speed regardless of print size, 2) misidentification of 3 words because he missed the beginning letters, 3) 1 word omitted on the left when beginning a new line of text, 4) as print size decreased, he moved the chart further away, 5) squinting and frowning as print size decreased—at one point he stopped and stated the print was blurry and hard to distinguish letters, 6) he reported a headache after completing the test.

RELATIONSHIP BETWEEN TEST RESULTS AND OCCUPATIONAL PERFORMANCE

The client's slow reading speed and observations 1-3 were consistent with a left HH that had extended into the foveal field, reduced the width of the perceptual span, and disrupted ability to see complete words and accurately complete a saccade to the left to pick up the next line of print. Observations 4-6 were not typically associated with HH but were consistent with difficulty focusing due to accommodative dysfunction. In addition the client's 20/50 reading acuity was 5 lines less than the reported distance acuity (20/15). This suggested a focusing deficiency since distance acuity does not require accommodation, but reading acuity requires increasing accommodation as print size decreases. The client's critical print size was 2.5 times larger than expected for a person with 20/50 reading acuity, which indicated that best reading speed occurred on print requiring less accommodation. At age 23, the client should have normal focusing ability unless he had a childhood eye condition that affected accommodation. He denied any childhood vision problems. Bilateral occipital lesions can cause blurred vision and a brainstem injury (which could affect the accommodative system) could occur from a severe whiplash injury. I used the MNread results, observations of the client's test performance, his medical history and my knowledge of the oculomotor system and hemianopsia to make the following determinations concerning his occupational performance: 1) the hemianopsia was interfering with reading performance, causing reduced reading speed and accuracy, difficulty navigating the page, and increased effort, 2) the client may also have an accommodative disorder limiting his ability to read standard size print and increasing reading effort, 3) current reading performance is not sufficient to enable the client to complete the reading demands required as a student.

5. Describe how **and** why you integrated these results into the client's intervention plan.

DISCUSSION WITH CLIENT

I described the evaluation results that suggested the HH was interfering with reading and the possible focusing deficiency due to a reason other than HH. I compared his reading speed to adult norms to help him understand how his performance had changed and could affect his ability to keep up in school.

GOALS

Together we identified two reading goals 1) improve reading speed, accuracy and ability to see standard size print, 2) to ensure that he could complete the reading required for school.

INTERVENTION PLAN

Use reading rehabilitation interventions and magnification as needed to increase reading speed and accuracy for goal 1; explore auditory-based assistive technology to replace vision in reading (e.g. a text to speech software program) to achieve goal 2. Before providing the intervention, I needed to determine why he experienced blurred vision and whether his reading acuity could be improved to enable him to read standard size print without experiencing blur or a headache. I planned to discuss the test results with my medical director to determine the best course to evaluate this complaint.

RATIONALE

I selected 2 reading goals because research has shown that reading speed and accuracy can be improved in people with HH who have normal language and visual attention. It was reasonable to expect that the client could improve his reading performance; however, research also has shown that HH reading rehabilitation cannot restore reading speeds to normal levels. Even if reading speed increased, the client would most likely be unable to meet the reading demands of graduate school. Since his ultimate goal was to resume his graduate studies, it was important to investigate alternative solutions to complete the required reading. Because of his age, we should be able to locate resources to purchase assistive technology through state or private sources. My rationale for seeking further assessment of his blurred

vision was that the ophthalmologist may have focused on the HH as the cause of the reading deficit and may not have thoroughly assessed acuity because the client achieved 20/15 on the distance acuity test. If the client didn't complain about blurred vision it was possible that a focusing deficiency was overlooked. Since focusing can be improved with glasses and other interventions, and reducing visual blur would enhance the client's ability to benefit from the reading rehabilitation for the HH, it was important to determine if something could be done to reduce the visual blur.

Part II

ASSESSMENT 2 (Part 2 of 2)

6. Name of assessment.

For the example, only 1 of the required 2 assessments was discussed.

7. Describe the client, client factors, and case contexts that contributed to your selection of the assessment for the identified case.

8. What considerations regarding reliability, validity, relevance, and currency did you consider when selecting this assessment?

9. Describe the assessment results, including those gathered through clinical observation, and what these results told you about the client's occupational performance.

10. Describe how **and** why you integrated these results into the client's intervention plan.

CLIENT-BASED CASE STUDY[Back to Criteria](#)**Criterion 7—Intervention: Performance Skills****Performs interventions that are unique to low vision while integrating impact of varying client factors and contexts.****Guidelines**

- Client-based case study should **not** include any form of standard client documentation (e.g., evaluation summary, discharge plan) or identification of client name(s) or facility information.

1. Date(s) case study represents

April 20XX

2. Describe the client, client factors, and case contexts for the identified case. The context of the case should be adequately communicated so that relevance and merit of the case to the criterion is easily determined. *(average word guideline–500)*Client:

Mrs. Perkins is an 89 year old female whose medical history includes macular degeneration (dry), s/p spinal fracture with subsequent back pain, and depression. Her low vision optometrist referred her to OT to address independence with ADLs and IADLs, eccentric viewing, use of optical devices, and home safety.

Relevant client factors:

- Visual acuity with eccentric viewing: OD 20/100; OS 20/125; OU 20/100; moderate contrast impairment. Visual complaints include difficulty reading for information and pleasure and trouble recognizing faces.
- Client reports difficulty with hearing while talking on the phone and in social situations when background noise is present. Client has not been evaluated for hearing aids.
- Depression: Geriatric Depression Screen (GDS) - 8/15 indicating possible depression. Client reports that her husband died 3 months ago and she moved from her home of 45 years to live closer to her daughter.
- Cognition: 8/28 on Short Blessed indicating moderate cognitive impairment.
- Physical performance: no significant limitations in arm or lower extremity function.
- Pain: Client reports 5/10 on analog pain scale due to her spinal fracture.

Relevant case contexts:

Mrs. Perkins lives in a 1 story ranch home accessible by 2 steps that is located 1 mile from her daughter, who is very supportive and visits her daily. She had several close friends in her hometown, which is 6 hours away, but has not made any social connections since the move.

Mrs. Perkins was referred for outpatient low vision rehabilitation at a university-based low vision clinic. Typically, clients are seen for the initial OT evaluation in the clinic and receive subsequent therapy in the home.

3. Articulate how this case demonstrates how you “perform interventions that are unique to low vision while integrating impact of varying client factors and contexts.” (average word guideline–500)

Immediate and long term implications of psychosocial adjustment issues:

Older adults encounter a variety of stressors, including decline in physical health, role changes, and loss of social support as family and friends pass away. The person may experience grief and depression in response to these losses. The immediate effect of grieving is a tendency to withdraw from daily activities and social participation, which can lead to clinical depression and withdrawal from daily activities. OT’s need to recognize these signs and work with clients to help them remain engaged in meaningful occupations.

Recognition of psychosocial issues:

Upon meeting Mrs. Perkins, I noted that she had a flat affect. Mrs. Perkins stated she felt “blue” and missed her husband, especially in the evening when things were quiet. She spoke of how difficult it was to leave her hometown and lifelong friends. She expressed concern about the burden she was placing on her daughter, who works full-time and has 3 children. Her daughter confirmed that her mother was struggling with adjusting to the loss of her husband and new surroundings. These observations, the client/family report, and the GDS scores led me to the conclusion that Mrs. Perkins most likely had depressive symptoms that needed to be addressed in order for her to benefit from therapy, adjust to changes, and achieve the best quality of life.

Modification of OT approach:

I applied therapeutic use of self in several ways. First, I needed to focus on how Mrs. Perkins’ sense of loss and life changes might impact her motivation to participate in OT and her ability to learn new strategies. I listened carefully, observed her non-verbal behavior (facial expression and body language), and asked her how she was feeling. I used active listening techniques to clarify her feelings and wishes. I also provided encouragement and appropriate use of touch, such as my hand on her arm, to comfort her.

Together we explored her priorities, and I observed her receptivity to initial recommendations and intervention strategies. I used this information to adjust the pace and direction of intervention. For example, Mrs. Perkins expressed frustration that she could not operate her new microwave, so I addressed that by marking the interface pad. She also demonstrated trouble grasping the concept of eccentric viewing, perhaps due to her cognitive status and possible depression, so I addressed other goal-related tasks that required less cognition to complete and revisited eccentric viewing during later visits.

I monitored Mrs. Perkins’ frustration level, affect, and other non-verbal signs throughout our sessions. If she began to appear anxious, I would offer breaks or redirect her to a simpler task. I allotted time for talking about any concerns, fears, and feelings of isolation. In addition, I solicited input from her daughter on how she felt her mother was coping.

I encouraged Mrs. Perkins to talk to her doctor about her low mood, anxiety and low back pain. I referred her to a low vision support group and to a senior center, to increase her opportunities for socialization, activity participation and exercise.

MENTORING RELATIONSHIP–MENTEE

[Back to Criteria](#)**Criterion 7—Intervention: Performance Skills**

Performs interventions that are unique to low vision while integrating impact of varying client factors and contexts.

Guidelines

- Must represent a **minimum of 10 hours** over a minimum of 2 months.
- Does **not** include supervisory relationships.
- Relationship must have occurred in the past 5 years.

1. Dates of mentoring relationship

[June 23, 20XX](#) to [Dec. 30, 20XX](#)

2. Approximately how many hours did this represent in total?

[80 hours](#)

3. Applicant's goals for mentoring relationship. *Goals must have been met by time of application. List no more than 3.*

A) [Learn how to plan and implement OT interventions for clients with vision impairment from acquired brain injury and neurological diseases.](#)

B) [Learn and model the role of the OT in low vision rehabilitation with brain injury](#)

C)

4.

Mentor	Mary Smith, MA, OTR/L, SCLV
Position/Role of Mentor	Director of Clinical Therapy
Workplace of Mentor	XYZ Rehab, Anytown, USA
Contact Information for Mentor <i>(email or phone number)</i>	msmith@email.com

5. State why the mentor was selected to help you meet the goals identified above relative to the criterion. *(average word guideline–50)*

I selected this mentor because she has practiced for 30 years as an OT working primarily with people with brain injury, with a focus over the last 5 years on vision impairments with this population. She received a graduate certificate in low vision rehabilitation, where she had formal education in evaluation and intervention for vision impairment from brain injuries. She is has her Specialty Certification in Low Vision from AOTA. She was responsible for supervising and mentoring new staff and field work students in vision rehabilitation.

6. Briefly describe how the knowledge acquired from this mentoring activity influenced your service delivery with clients, specific to your ability to *“perform interventions that are unique to low vision while integrating impact of varying client factors and contexts.”* *(average word guideline–200)*

Mary provided me a reading list for self-study that focused on common vision impairments caused by brain injury, screening assessments, and interventions. I spent 3 weeks shadowing Mary, who provided interventions in the clinic and on home visits. I began to assume intervention responsibility for clients admitted to the program until I reached a caseload of 6 per day. I met formally with Mary once a week and informally as needed each day to share ideas and feedback. In our meetings, we discussed the impact of client factors associated with brain injury, including changes in cognition, motor function, and emotional regulation, and how these factors interacted with vision impairment in the context of ADLs and IADLs. I prepared written intervention plans for each client. Mary asked questions and provided options for me to consider that ensured I addressed each client's range of issues.

Specific intervention approaches that I learned included modifying the environment and tasks to reduce visual stress by increasing contrast, using the best light source, reducing pattern, reducing visual steps, and structuring tasks. I learned to implement visual scanning training for clients with hemianopsia and neglect, and how to implement reading strategies for clients with hemianopsia. I also learned how and when to apply partial occlusion for clients with double vision from oculomotor impairment, and how to consult with ophthalmologists and optometrists concerning vision issues from brain injury.

FORMAL SPECIALIZED CONSULTATION FOR INTERVENTION[Back to Criteria](#)**Criterion 8—Intervention: Critical Reasoning****Selects, plans, and modifies interventions in low vision based on evidence and evaluation data.****Guidelines**

- This should **not** be confused with consultation that is part of the ongoing services provided in your routine job duties but is a request to address a particular issue at a particular site, either external or internal.
- Consultation may include (but is not limited to) developing or evaluating a program or service, developing a strategy for long-term planning, establishing outcomes measures, incorporating national guidelines into internal policies and procedures, assessing and addressing staff educational needs, assessing and addressing resource needs, and validating program/service delivery with current evidence.
- Applicant must have had a **minimum of 10 hours** working with the site.

1.

Entity for Which Consultation Was Completed	The Church of Perpetual Love
Date(s) of Consultation	July 1, 8, 15, 22, 29, 20XX
No. of Hours Completed During Consultation	40 hours

2. Objectives for consultation. *Objectives must have been met by time of application. Please list no more than 3.*

A) To educate church board members, and a team of construction engineers and architects on how low vision affects a person's ability to interact and participate in the built environment.
B) To assess the church environment and identify barriers that limit the participation of church members with low vision.
C) To recommend environmental modifications that would promote full participation of members in church activities.

3. Summarize the consultation results. *(average word guideline–200)*

<p>The church was undergoing a remodeling project of the sanctuary. Many of the older church members had an eye condition that made it difficult for them to 1) read in the sanctuary, 2) move about the sanctuary due to fear of falling, 3) socialize with friends due to poor lighting.</p> <p>I completed an environmental assessment and made the following lighting recommendations: 1) add LED clip-on book lamps in the pews for members who need additional lighting, 2) repaint the walls with a light color to increase reflective light, 3) change the carpet color to contrast from the pews and floor and provide a more visible pathway through the sanctuary, 4) add strips of LED lights in the sanctuary along the pathway to the seating area and on the steps, 5) change the incandescent light bulbs, used in the ceiling, to halogen to increase lighting without adding glare.</p> <p>I presented the recommendations to the church board, who approved the plan. I met with the contractor to explain the rationale for the modifications and the specifications. All of the recommendations were implemented. After the remodeling, feedback from the members was favorable.</p>

4. Summarize how this professional development activity influenced your ability to “select, plan, and modify interventions in low vision based on evidence and evaluation data.” (average word guideline–400)

I had limited experience in a consultative role, and the project provided an opportunity to improve my critical reasoning skills. Prior to the environmental assessment, I reviewed literature on lighting requirements of public spaces and talked to a lighting contractor about the types of lighting that could be installed in public buildings. I interviewed several older church members with low vision to understand the difficulties they were experiencing while participating in church services. I attended a service to observe members interacting in the environment and to identify reading and mobility demands. I met with the church board to understand the budget for this project.

This assessment process was different than the one I had used in a direct care situation, because the sanctuary was used by many older adults with a variety of vision disorders and range of needs. I kept this in mind throughout the assessment process. For example, some congregants required high lighting levels, while others had light sensitivity and were more comfortable in moderate lighting environments.

This consultative role reinforced the value of using a light meter when assessing home and community environments. In my low vision practice, I did not routinely use a light meter. However, for this project, light meter readings were instrumental in determining where and how lighting needed to be modified. I provided objective pre- and post-lighting modification data that helped the contractor understand the value of properly directed task lighting for reading, and ambient lighting for safety and socialization. I now use a light meter routinely to assess lighting needs. I also question clients about their ability to use public spaces, and I focus more on community mobility.

As I developed my recommendations, I had to meet all of the stakeholders’ needs. The congregants’ needs were my first priority, but I also had to make sure that budget constraints were met. I prepared my list of recommendations in priority order, and provided specific modifications with an evidence-based rationale that included function and safety considerations.

PROGRAM DEVELOPMENT

[Back to Criteria](#)**Criterion 8**—Intervention: Critical Reasoning**Selects, plans, and modifies interventions in low vision based on evidence and evaluation data.****Guidelines**

- *Program development* refers to the creation of a new program or development of an evolving program.

1. Dates of program development

June - September, 20XX

2. Briefly describe the program purpose, services offered, and clients served. (*average word guideline—250*)**Program:** Keep Moving with Low Vision**Purpose:** To provide a safe and accessible opportunity for exercise and fitness programs for older adults with low vision.**Services Offered:** Exercise and fitness programs for older adults with low vision, including chair-based and aquatic exercise classes designed to progressively build strength, flexibility, and endurance in a refreshing and joint-supportive environment. The aquatic classes use the water's buoyancy and resistance to help improve joint flexibility.**Clients Served:** Individuals with vision deficits due to glaucoma, diabetic retinopathy, macular degeneration, cataracts, and other low vision diagnoses.3. Describe how this program development activity, including description of resources used, demonstrates your ability to “select, plan, and modify interventions in low vision based on evidence and evaluation data.” (*average word guideline—500*)

Exercise programming is not a typical area of intervention for OTs working in LV rehabilitation; however, the department where I work was approached by the local Jewish Community Center (JCC) to assess the needs of their older adult members with vision loss. The JCC wanted to know if their facility and exercise classes met the needs of member with low vision. They were also interested in environmental modifications to make the facility more visible, and requested program development services to implement exercise classes for those with vision loss. I was asked by my supervising OT to assist her in this process.

Use of Evidence

My first step was to review the literature on the benefits of exercise. Physical activity is linked to lower mortality rates and decreased risk of cardiovascular disease, stroke, diabetes and depression (Brach, Simonsick, Kritchevsky, Yaffe & Newman, 2004; Chodzko-Zajko). Benefits of physical activity for persons with low vision has also been established (Knudtson, Klein & Klein, 2006; Seddon, Cote, Davis, & Rosner, 2003; Williams, 2009). Despite strong evidence supporting the benefits of regular exercise, the CDC (2007) reports that the majority of adults, age 65 and over, do not engage in physical activity.

Needs Assessment Process

I assisted the OT with conducting a needs assessment process using a 4-step approach: 1) 22 older adult members (14 female, 8 males) agreed to complete the Physical Fitness and Exercise Activity of Older Adults Scale (Melillo, Williamson, Futrell, & Chamberlain, 1997) and the Exercise Benefits/Barriers Scale Sechrist, Walker, & Pender, 1987), 2) We facilitated a group discussion for 8 additional older adult members that focused on their interests, needs, perceived barriers to exercise, etc., 3) We met with JCC certified trainers and exercise class instructors to gain their

perspective, 4) The OT and I completed an environmental assessment of the facility. We combined this information with our expertise in low vision to address the JCC's goals. In addition, we frequently consulted with members and exercise instructors, who participated in the needs assessment at key points in the program planning process to ensure that our recommendations fit their needs.

Intervention/Recommendations

Recommendations for increasing general and visual accessibility of the JCC included glare reduction strategies in the lobby and indoor pool area, adding lighting in the locker room, enlarging numbers on the lockers, increasing contrast on floor surfaces, steps and railings, marking controls on exercise equipment, making boundaries on the basketball and volleyball courts more visible, organization of exercise equipment, modification of signage and use of large print class schedules.

I partnered with 2 certified trainers/exercise instructors to create a chair-based and aquatic exercise class tailored to members with low vision. First, I recommended that participants be screened for vision, hearing, balance, strength, general fitness level and history of falls. For both classes, the instructors wore solid, bright leotards and gloves and used a microphone. For the chair-based class, JCC staff set up the room in advance with contrasting chairs placed in rows and equipment placed underneath the chairs. Trekking poles and beeping balls were available if needed. The instructor stood in front of a plain wall so that her motions would be more visible, and she used descriptive language to help patrons visualize required movements. For example, she would tell them to make motion like "kneading bread." People in the aquatic aerobics class were paired with a buddy to help safely access the pool area, which had many low contrast features that could not be easily modified.

Three months after the project ended, I surveyed members and staff to determine whether program outcomes had been achieved and maintained. I found that the instructors for the aquatic and exercise programs had continued to use the teaching strategies identified above, and enrollment in these programs had increased by 25%. The facility had implemented most of the lower cost modifications, including adding more lighting, providing large print materials, and larger signage. More expensive modifications, such as modifying windows to reduce glare, were in the budget process.

Summary

This program development experience challenged and strengthened my critical reasoning abilities. I learned the importance of completing a needs assessment as the first step in developing a program. The information we compiled helped me understand our clients' needs and ensure that our recommendations met those needs. I learned how to balance the needs and goals of multiple parties (JCC members, administrative staff, and exercise class instructors) and negotiate and compromise when needed. I also learned the importance of frequently soliciting feedback from stakeholders during program development, and to add a program evaluation piece to determine if program outcomes were met

RESEARCH[Back to Criteria](#)**Criterion 8**—Intervention: Critical Reasoning**Selects, plans, and modifies interventions in low vision based on evidence and evaluation data.**

What type of research was conducted? Please choose 1.

- Scientific inquiry**—Qualitative, quantitative, or mixed-methods approach.
- Methodological research/instrument development**—Scientific inquiry to establish psychometric properties of (1) a new tool, (2) an existing tool with a new population, or (3) an existing tool translated to a new language.
- Systematic review of the literature**—Comprehensive search, review, and analysis of the existing literature to answer a focused question.

1. Title of research conducted

Reading Vertical Text – A New Approach in Hemianopic Dyslexia Rehabilitation

2. Mechanism of dissemination:

- Publication Evidence-Based Practice
- Peer-reviewed presentation Project Web site
- Grant funding Dissertation/thesis
- Critically Appraised Topic (CAT, e.g., AOTA)

Citation:

Submitted as a 2 year R21 grant to the National Institutes of Health

3. Role of applicant in the research. *(average word guideline–25)*

Co-principle investigator responsible for managing the vertical text trial, including participant recruitment, designing training protocols, and conducting and supervising staff to conduct the intervention.

4. Purpose and rationale of the research. *(average word guideline–250)*

Homonymous hemianopia (HH) occurs frequently in clients with acquired brain injury from stroke, trauma or tumors. Clients with HH frequently experience difficulty reading because half of the horizontally positioned words and text lines are not visible. This results in reduced reading speed, accuracy and poor fluency. Due to difficulties in reading, clients with HH often report that they are unable to complete ADLs that are dependent on reading, including financial management and personal communications (Warren, 2009). Rotating the text 90 degrees clockwise (for right HH) or counter-clockwise (for left HH) so that the text is read vertically restores the visibility of entire words and text columns to the client. In addition, VT text display can readily and inexpensively be achieved by rotating paper reading materials (e.g. books, newspapers, pill bottles), electronic devices, and computer monitors. If vertical text (VT) reading can be shown to be a faster, more fluent, and more easily-learned alternative to horizontal text reading (HT), it would offer an inexpensive and practical intervention for improving reading performance in clients with HH.

The purpose of the research was to develop and test a VT rehabilitation protocol and to assess its benefit relative to the HT reading intervention, which is the current standard of practice. A 2 year, randomized controlled VT training trial was submitted to the National Institutes of Health (NIH) to fund the study.

5. Describe how this research demonstrates your ability to “select, plan, and modify interventions in low vision based on evidence and evaluation data.” *(average word guideline–400)*

Selection of the intervention: I observed that my clients who received reading rehabilitation emphasizing strategies to read horizontally oriented text were usually able to increase their reading accuracy, as evidenced by improved accuracy scores on the Visual Skills for Reading Test (VSRT). However, their reading speed on the VSRT and the MNread acuity chart typically did not increase significantly, and clients continued to report that reading was difficult. I met with a vision researcher, who was interested in reading rehabilitation for people with HH. We discussed whether or not changing the orientation of the text so that it is read vertically could improve reading performance. We jointly conducted a literature review and found no empirical studies had been completed on this technique, but there was a sound psychophysical rationale supporting the possibility that it would be effective.

Planning the intervention: My role in the study design was to develop an intervention protocol that could easily be replicated in a typical low vision clinic. To develop a practical and feasible protocol, I determined that the intervention must meet 4 criteria: 1) low cost; requiring no special equipment, 2) require no more than the typical number of therapy visits covered by medical insurance, 3) require no more than typical therapist/client interaction, 4) motivate the client to practice reading. Using these criteria, I developed a 4-week intervention that utilized a 15-minute interaction with the therapist during the clinic session and a set of 30 minute home program daily exercises that used graded and standardized reading materials. The intervention included lists of words, paper and pencil exercises and short continuous text stories that the participant would complete using either a vertical or horizontal reading strategy.

Modification of the intervention: Since the intervention relied on home practice, it was important to use materials with subject matter appropriate for adults in order to engage them. The materials also needed to be written at a lower reading grade level so they would not frustrate the participant. I met with adult literacy experts to locate sources of reading materials that had lower reading grade levels, but still contained adult content for more interesting reading. I incorporated these reading materials into the intervention protocol.

MARKETING ACTIVITIES

[Back to Criteria](#)

Criterion 11—Establishes Networks

Establishes and collaborates with referral sources and stakeholders to help the client and relevant others achieve outcomes that support health and participation in the area of low vision.

Type of media used for marketing: (check all that apply)

- Presentation to potential referral source audience
- Presentation to potential clients
- Participation in community event such as health fairs

X [Speaking to community groups](#)

- Development and dissemination of marketing materials (e.g., brochures, Web sites, podcasts)
- Participation in media interview (e.g., television news, newspaper)
- Other

1.

Target Audience of Marketing	Low vision support groups
Date(s) of Marketing Efforts	8/15/20XX, 9/12/20XX, 10/18/20XX, 11/21/20XX
Approximate Total Hours Engaged in Marketing Activity	5 hours: 1 hour to design and create the presentation and 4, 45 minute presentations each with a 15 minute question & answer period

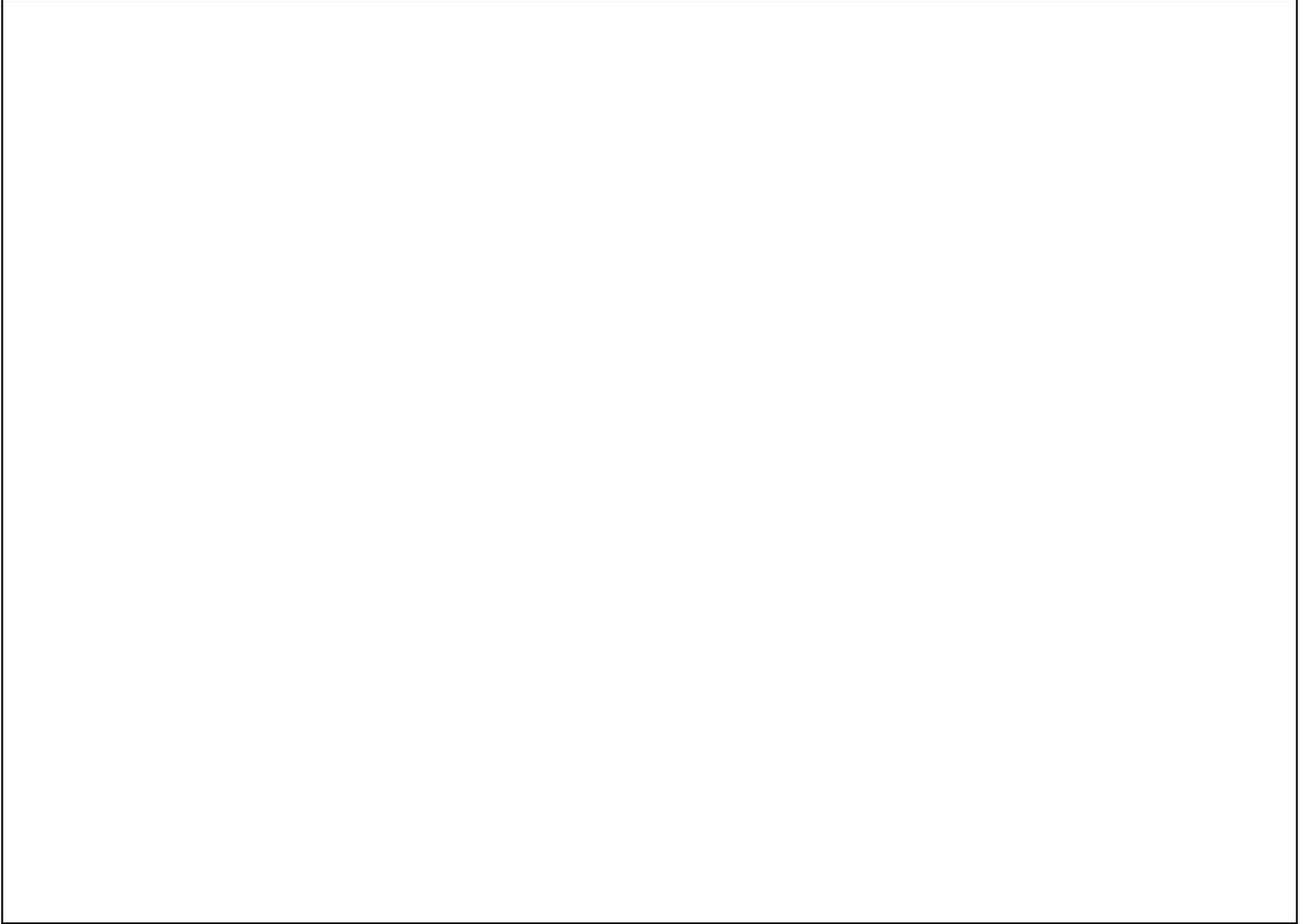
2. Provide a brief summary of the marketing activity. *(average word guideline–50)*

An interactive and educational presentation for local low vision support groups designed to promote the benefits of low vision rehabilitation and how to obtain occupational therapy services. Includes hands-on experience for each participant to facilitate understanding of how therapy can maximize the ability to use remaining vision.

3. Applicant's objectives for the marketing. *List no more than 3.*

- | |
|---|
| A) Develop participant understanding of how low vision rehabilitation fits within the continuum of vision care for persons with age-related eye disease including how, when and from whom to seek referral for services. |
| B) Provide local and national resources to assist participants in locating services and accommodations to help them live well with low vision. |
| C) Demonstrate occupational therapy interventions such as lighting, contrast, use of other senses, organization, training in the use of optics, and eccentric viewing training to assist participants understand how they can improve their ability to use remaining vision and increase safety and independence. |

4. Describe how this marketing activity demonstrates how you "establish and collaborate with referral sources and stakeholders to help the client and relevant others achieve outcomes that support health and participation in the area of low vision." (average word guideline–200)



PRESENTATION[Back to Criteria](#)**Criterion 11—Establishes Networks**

Establishes and collaborates with referral sources and stakeholders to help the client and relevant others achieve outcomes that support health and participation in the area of low vision.

Type of presentation:

In-service to professionals

Academic program lecture

Professional level workshop (e.g., state conference)

Community

1. Presentation information.

Title	Low Vision Simulations: Understanding the Lived Experiences of Individuals with Low Vision
Target Audience	State Blindness Association caseworkers
Date and Time of Presentation	October 18, 20XX

2. Brief description of the presentation, including content focus. *(average word guideline–50)*

I used glasses that simulated visual changes from age-related eye diseases to help the audience experience how low vision affects performance of tasks requiring reading, writing, mobility, and eye hand coordination. I provided information on simple task and environmental modifications to enhance vision use in people with low vision.

3. Applicant's objectives for networking. *Objectives must have been met by time of application. Please list no more than 3.*

A) Enable participants to understand that people with low vision have impaired but useable vision that can be enhanced with adaptive techniques.

B) Demonstrate how low vision rehabilitation can improve occupational performance.

C) Provide information on how to obtain a referral to receive low vision therapy services.

4. Describe how networks were established or strengthened through this presentation and any changes which have occurred as a result of your presentation. *(average word guideline–200)*

The majority of the blindness association members in my community are completely blind. However, people with low vision are increasingly joining the organization. I discovered that blindness association caseworkers in my area had a limited understanding of how the needs of people with low vision differ from those who are blind.

Audience feedback indicated that my presentation increased the caseworkers' understanding of how low vision affects ADL performance and how low vision rehabilitation can help people use their vision more effectively. The presentation significantly increased my interaction with the caseworkers. I consult with them frequently now on individual member needs and help locate resources. They have referred numerous clients to me, and since I need a physician's referral to see a client, I was able to introduce my services to eye care professionals when I contacted them for a referral. The greater awareness of my services among local eye care professionals has resulted in increased direct referrals from them.

As a result of the presentation, I have been able to establish a larger network of referral sources for my low vision practice.

ADVOCACY EFFORTS

[Back to Criteria](#)

Criterion 12— Advocating for Change

Influences services for clients (person, organization, population) in low vision through independent or collaborative education or advocacy activities.

Guidelines

- Active involvement in or facilitation of advocacy activities at the local, regional, state, or national level for the purpose of influencing decision-makers about policy, procedures, services, reimbursement, or occupational justice issues.
- Merely serving as a participant does **not** constitute advocacy efforts.
- **Minimum of 10 hours** over at least 2 months.

Type of advocacy activity: (check all that apply)

- Development and dissemination of advocacy materials (e.g., letters, brochures, Web sites, podcasts)
- Lobbying to/education for policy-makers
- Organizer of community event (e.g., fundraising, health fair)
- Subject expert in media interview (e.g., radio, television news, newspaper)
- Presentation to stakeholder
- Other

1.

Description of Activity	Target Audience	Date(s)	No. of Hours Involved
Presentations on low vision and need for optical devices to obtain support for the fundraiser.	Priest, church outreach committee, center staff, community center, Rotary club, Knights of Columbus, Polish Society	8/XX/XX, 8/XX/XX, 8/XX/XX 9/XX/XX, 9/XX/XX, 9/XX/XX, 9/XX/XX	20 hours
Contact with optical device vendors to obtain donations, discounts	XYZ Vendor QRS Vendor	10/XX/XX, 10/XX/XX	5 hours
Planning committee meetings	Members involved in planning event	9/XX/XX, 9/XX/XX, 10/XX/XX, 10/XX/XX, 10/XX/XX, 10/XX/XX, 10/XX/XX, 11/XX/XX, 11/XX/XX	20 hours
Marketing the event	Media outlets: newspapers, radio, television; Community events	10/XX/XX, 10/XX/XX, 10/XX/XX, 10/XX/XX, 10/XX/XX, 10/XX/XX	10 hours

2. Applicant's objectives for advocating for change. *List no more than 3.*

A) Obtain assistive technology, low vision devices and eyeglasses for residents in a low-income housing facility for older adults.
B) Raise community awareness of low vision and the need for good eye care in a low-income neighborhood.
C)

3. Discuss the results, outcomes, or progress toward change affected by this advocacy effort that demonstrates how you *“influence services for clients (person, organization, population) in low vision through independent or collaborative education or advocacy activities.”* (average word guideline–350)

I worked with clients residing in a low-income housing facility for older adults. Most residents lived on social security only and were under-insured. In providing services, I became well-acquainted with the facility and staff, including social workers, activities director and facilities director. The facility is located in a large urban area in a poor neighborhood known as Poletown. Most of the residents grew up here and were members of a large Catholic church located across the street from the housing facility. The church provided several outreach services to the neighborhood. My clients responded well to low vision rehabilitation but most could not afford the cost of optical devices that could help them maintain their independence.

After a client and I made a batch of cookies to learn meal preparation skills, I joked that we should sell them to raise money to buy optical devices. My client, a life-long activist, took the idea to her church circle. They agreed that they should have a bake sale to raise money. From that idea came “Sweet Sights,” an annual bake sale and food event featuring Polish delicacies. The event, now in its third year, has raised over \$7,000 to purchase optical devices and eyeglasses for facility residents.

I played an active role in bringing this idea to fruition. To solicit support for the project, I met with the priest, church outreach committee, and housing facility staff to explain low vision and how optical devices enable people to complete important ADLs. I served on the planning committee, and approached several optical device vendors for donations and discounts. I helped market the event, including talking to media, and speaking at community gatherings about the challenges seniors experience paying for devices and the difference these devices can make in their lives. In year 2, we had a vision health fair. I arranged for optometry students to complete vision screenings. In addition to serving as a standing member of the planning committee, I serve on the budget and finance committee to help determine how funds will be used to purchase devices.

Our efforts have raised awareness of low vision and the need for good eye care within the community. We have purchased a stand-alone CCTV for all of the residents to use, along with devices for individual residents. We created a lending library of devices to share among residents and purchased new eyeglasses for 25 residents.

ADVOCACY CASE STUDY

[Back to Criteria](#)

Criterion 12— Advocating for Change

Influences services for clients (person, organization, population) in low vision through independent or collaborative education or advocacy activities.

Guidelines

- Efforts toward change that influence access to services or promote the health and occupational engagement of clients.
- This should **not** be confused with routine job duties associated with expected occupational therapy service delivery. For example, submitting letters of necessity for equipment would not meet intent.

1. Describe the client (person, organization, population) or program and the context as it applies to an identified need for change. *(average word guideline–100)*

I work in a university-based clinic serving older adults. My typical client is female, in her mid 80's, widowed, retired from driving, and struggling to remain independent and in her own home. Though my clients are not diagnosed as clinically depressed, they frequently express that they feel alone and isolated because of their eye disease and frustrated by their limitations. At discharge they often express concern that they will lose ground or miss out on new developments in treatment. Our clinic does not offer a support group because it is not a billable service, and there are no community support groups.

2. Summarize your efforts to influence change. *(average word guideline–200)*

I realized that there were no services in place to meet the long-term needs of our clients with low vision. I conducted a needs survey of current and recently discharged clients. Sixty percent of the respondents expressed an interest in attending a group, and identified their primary barrier as transportation and their primary motivation as receiving up-to-date education and resources.

Recognizing my facility's concern about resource allocation, as well as the clients' concern regarding access to a group, I met with 2 potential partners: 1) an OT faculty member, who agreed to use the process of exploring group development as a student research project, and 2) a private organization that provided transportation for children to medical appointments on campus.

Ultimately the school's Student Occupational Therapy Association (SOTA) agreed to take the group on as a permanent project and provide long term volunteer help.

3. Describe the change outcomes or progress toward change as a result of your efforts. *(average word guideline–200)*

- Six months were required to develop and launch the support group, which has now been operating for 2 years.
- The group meets once a month and 2 SOTA student volunteers attend and help facilitate each meeting.
- The transportation service continues to transport 4 persons to the meeting.
- Quality assurance measures were established for attendance and client satisfaction. These measures have shown that monthly attendance averages between 15 and 20 clients and family members. Usually 1-2 new participants join the group each month.
- Participants report that they find the educational content and resource information to be useful; they also report that they enjoy interacting with the SOTA students and receiving support from each other.

4. Articulate how this case demonstrates your ability to “influence services for clients (person, organization, population) in low vision through independent or collaborative education or advocacy activities.” *(average word guideline–500)*

When advocating for this support group, I had to balance the needs of the consumers (clients and families) with those of the low vision clinic. To be sustainable, the program had to provide useful information and support to the consumers on a day and time when they could attend; but also, not interfere with the clinic’s service delivery or reducing the billable treatment units for OT.

I could not provide the low vision support group by myself without reducing my caseload, so I sought a collaborative relationship with the university’s OT program to provide volunteer manpower for the group. I was aware that OT students were required to conduct research and provide community service with a faculty advisor, so I presented the low vision group as an opportunity for an ongoing community health research project, and I offered to supervise the student effort. This also aligned with our clinic’s mission to provide educational opportunities to students, which increased the clinic’s support for the project. Obtaining SOTA support guaranteed that I would have volunteers capable of developing good educational and resource programs for the participants.

The initial needs assessment identified transportation as a barrier for some. I was aware of a well-funded private organization that provided transportation for children to doctor’s appointments and arranged a meeting with the executive director. A major objection was the estimated amount of time required and the demand for services, which could take away from their primary mission to serve children. I emphasized that we only needed assistance one day per month, and that our clinic was located close to the children’s hospital clinics. To make it easier for the drivers, our student volunteers would meet the clients as they arrived and also deliver them to the bus for pick up.

This case represents a good example of how I was able to influence both the creation of and accessibility to services. My initial observations of client need were substantiated with data, and I was able to work with multiple groups to meet these identified needs.

PUBLIC AWARENESS EFFORTS[Back to Criteria](#)**Criterion 12— Advocating for Change****Influences services for clients (person, organization, population) in low vision through independent or collaborative education or advocacy activities.****Guidelines**

- Development of public awareness media for a broad audience to promote topic(s) relevant to the specialty area.

Type of media developed: (check all that apply)

- Presentation to potential referral source audience
- Presentation to potential clients
- Participation in community event, such as health fairs
- Speaking to community groups
- Development and dissemination of marketing materials (e.g., brochures, Web sites, podcasts)
- Participation in media interview (e.g., television news, newspaper)
- Other

1. Target audience(s) of public awareness.

Target Audience of Public Awareness Efforts	Public radio audience
Date(s) of Public Awareness Activity	<ul style="list-style-type: none"> • Interview: October 18, 20XX • Response to web postings: October 19-November 15, 20XX
Approximate Total Hours Engaged in Public Awareness Activity(ies)	<p>Approximately 7 hours:</p> <ul style="list-style-type: none"> • 2 hour preparation time • 1 hour panel with ophthalmologist, low vision optometrist, older adult with low vision and her daughter • 4 hour follow-up answering questions from listeners via email and radio station web site

2. Brief Summary of the Public Awareness Message (*average word guideline–50*)

Interview message: Low vision rehabilitation can assist people in continuing to live independently in their homes and participate in valued occupations. There are many resources available. Ask your eye doctor if low vision rehabilitation can help you or contact a local agency for more information.

3. Applicant's objectives for advocacy/change. *List no more than 3.*

- A) Develop awareness and understanding among the public of low vision rehabilitation as part of the continuum of care for older adults with low vision due to age-related eye disease.
- B) Develop awareness among the public of the variety of services available to older adults with low vision and how to obtain services.
- C) Develop awareness and understanding among the public of the benefits of receiving low vision rehabilitation to increase safety and independence within the home and community.

4. Summarize the changes that have occurred (or progress toward change) as a result of your public awareness efforts and how this activity demonstrates that you *“influence services for clients (person, organization, population) in low vision through independent or collaborative education or advocacy activities.”* (average word guideline–200)

I served as the low vision rehabilitation expert on the panel and covered services available within the community. The media interview was made available as a podcast and was rebroadcast twice in the month following the original interview. It was posted on the station website and is available for download. The website includes a public forum for people to post comments and ask questions. The web site received 25 comments and questions during the 1 month period following the interview. Nearly half of the viewer posts focused on low vision rehabilitation services and I provided answers to any questions. This public response suggests that the radio program increased the public’s awareness and interest in low vision rehabilitation.

The web site postings came from a broad range of stakeholders, including general practitioners, nurses, social workers, people with low vision, family members, and caregivers. As a result of the interview, I received a request from the local senior center to provide a talk on low vision rehabilitation. In addition, our center was invited to provide a booth and speak about low vision rehabilitation at a large, local health fair for older adults. Involvement in these activities served to further enhance public awareness of the role of low vision rehabilitation and related community services.

VOLUNTEER LEADERSHIP[Back to Criteria](#)**Criterion 12— Advocating for Change**

Influences services for clients (person, organization, population) in low vision through independent or collaborative education or advocacy activities.

Guidelines

- Service with a local, state, national, or international agency or organization that has relevance to the criterion.
- **Minimum of 25 hours** for at least 1 year.

1. Name of organization

[Low Vision Support Group](#), local affiliate of the International MD Support group (www.mdsupport.org).

2. Dates of service

2 years from July 1, 20XX through June 30, 20XX.

3. Approximate number of hours of service

75 hours.

4. Identification of the volunteer leadership role served (must be leadership in nature, e.g., officer, chair, committee member, board member)

Chairperson

5. Describe how this leadership activity helped you *“influence services for clients (person, organization, population) in low vision through independent or collaborative education or advocacy activities.”* (average word guideline–400)

I served as the chairperson for the [Low Vision Support Group](#). I helped organize monthly meetings and secure local vision specialists as speakers. I worked with the MD Support group liaison to set up networking sessions or obtain videos for the meetings. I helped to market the support group by distributing flyers to a local senior center, several assisted living centers, and offices of optometrists, ophthalmologists and medical clinics. I also chaired the committee that wrote and distributed public service announcements to local radio stations and newspaper.

During my term, the size of the group doubled through my close work with local media outlets and distribution of marketing materials to local stakeholders serving older adults. Regular distribution of materials to eye care specialists and doctors enabled us to establish relationships with these professionals and expand the diversity of our speaker pool. Our speaker bureau now includes: 5 optometrists, 4 ophthalmologists (including 2 retinal specialists), a social worker, a certified diabetes educator and several primary care physicians. The diversity of speaker backgrounds has enabled us to offer information on a variety of topics that are important to our members' ability to live well with low vision.

The increased number of participants attending each month has added more energy to the meetings. Members provide emotional support to each other by sharing experiences and discussing strategies to accomplish ADLs in more efficient ways. Members have formed car pools to help each other get to meetings. One of the most important outcomes that I have observed is the improved mood and optimism among members who attend regularly.

ETHICAL PRACTICE SCENARIO (Part 1 of 3)—Client Based[Back to Criteria](#)**Criterion 10—Ethical Practice: Client-Based**

Identifies ethical implications associated with the delivery of services in [area] and articulates a process for navigating through identified issues.

Guidelines

- The applicant identifies ethical implications associated with the delivery of services and articulates a process for navigating through the identified issues.
- The applicant shall review the [AOTA Code of Ethics and Ethics Standards](#) and align the dilemma with the ethical principle(s) that is/are challenged.

Ethical Scenarios**Scenario #1**

An OT practitioner works for an optometrist who sells every client at least 2 magnifiers before they are referred for therapy. All sales are final and the client cannot return the device unless it is defective. *[For sample purposes only]*

Scenario #2**Scenario #3**

1. To which scenario are you responding? **Scenario #1**
2. From the [AOTA Code of Ethics and Ethics Standards](#), which ethical principle(s) has/have been challenged in this scenario? *Select the top ethical principle(s) that apply, up to a maximum of 3.*

<input checked="" type="checkbox"/> 1. Beneficence	<input checked="" type="checkbox"/> 5. Procedural Justice
<input checked="" type="checkbox"/> 2. Non-maleficence	<input type="checkbox"/> 6. Veracity
<input type="checkbox"/> 3. Autonomy, Confidentiality	<input type="checkbox"/> 7. Fidelity
<input type="checkbox"/> 4. Social Justice	

3. Describe how you would apply the ethical principles identified above to guide you toward a resolution for the concern noted. *(average word guideline—500)*

The central ethical concern is one of fairness for the client. The client deserves to be provided with the best magnifier to meet their needs. The optometrist's policy places the client at risk for receiving less than optimum intervention to meet their occupational therapy goals. For example, it is possible that the optometrist prescribed a magnifier that worked well during the low vision exam, but does not satisfy the client's needs for completing ADLs at home. I should be able to collaborate with the optometrist to identify a more effective magnifier, and the client should be able to return the magnifier for a full refund.

To resolve this issue, I would use principles 1-B and 2-C to guide my decision-making. Principle 1 addresses beneficence and requires me to "demonstrate concern for the well-being and safety" of the client, and 1-B requires me to provide an appropriate intervention specific to client needs. Magnifiers are the principal adaptive device people use to compensate for reduced acuity. A poorly prescribed device could limit the client's ability to complete ADLs and reduce the client's independence and well-being. It could also potentially affect safety if the device is used for a high-risk area like medication management.

Principle 2 addresses non-maleficence and the duty to refrain from harming the client. 2-C directs me to avoid a relationship that exploits a client psychologically, emotionally or financially. Requiring a client to purchase a non-refundable device before they are trained to use it in ADLs has the potential to inflict harm by causing frustration, reduced self-efficacy and hopelessness if the device does not meet their needs. In addition, the client could be financially harmed because devices are not covered by insurance, and 2 devices can cost over \$100 which is a significant amount for clients on a fixed income.

I would also draw on principle 5, procedural justice, directing me to advocate for fair treatment of clients. I would use principle 5-B and 5-N to address the issue with the optometrist. 5-B directs me to open a dialogue with the optometrist to discuss the no return policy so I can understand why the policy exists. If a device is not working, 5-B also directs me to explain to the optometrist why it is necessary to refund the cost of the device. 5-N directs me to advocate for revising the policy to permit the return of devices and identify the conditions under which they can be returned.