Low Vision FAQs

**Question 1:** What does the term *low vision* mean?

**Answer:** According to the National Eye Institute (2008), low vision is defined as a visual impairment that is not correctable by standard eyeglasses, contact lenses, medication, or surgery and that interferes with the ability to perform everyday activities.

**Question 2:** How is the diagnosis of low vision made?

**Answer:** According to the Centers for Medicare & Medicaid Services (2002), the diagnosis of low vision is made by an eye care physician and is solely based on visual acuity or visual field deficits. Even though other visual impairments—such as double vision or visual processing deficits—may interfere with the ability to perform everyday activities, these conditions are not considered low vision.

**Question 3:** How common is low vision?

**Answer:** In 2002, Lighthouse International estimated that nearly 10 million Americans had some form of visual impairment that affected their everyday life. Age-related eye diseases are the most common cause of low vision, with more than 18% of adults 70 years of age and older reporting a visual impairment that hinders their ability to complete functional tasks. The rate of visual impairment increases with age, with 15% of individuals aged 45 to 64 years, 17% of those 65 to 74 years, and 26% of those over the age of 75 reporting some form of visual impairment (Leonard, 2002; Prevent Blindness America, 2008). Occupational therapy practitioners working in any geriatric practice setting will need to be prepared to address the visual needs of their clients.

**Question 4:** How does low vision relate to AOTA’s Centennial Vision?

**Answer:** The American Occupational Therapy Association's (AOTA's) Centennial Vision for the profession's 100th anniversary in 2017 states, "we envision that occupational therapy is a powerful, widely recognized, science-driven, and evidence-based profession with a globally connected and diverse workforce meeting society's occupational needs" (AOTA, 2006).
In addition to identifying actions needed to make the Vision a reality, AOTA identified six practice areas around which to focus Centennial Vision efforts. Health and Wellness, and Productive Aging are two of those practice areas.

Expanding the role of occupational therapy in low vision by helping older adults use their remaining vision to participate in desired occupations supports their need for healthy and productive lives. Similarly, modifying the home environment to facilitate individuals' safe participation in daily activities contributes to overall health and wellness.

Meeting societal occupational needs helps to increase public recognition of our profession and helps make the Centennial Vision a reality.

**Question 5: Where can I learn more about the role of occupational therapy in low vision?**

**Answer:** AOTA has many helpful resources for occupational therapy practitioners interested in learning about the provision of low vision services. Some of those are listed below.

**Fact Sheet**


**Articles**


**Practice Guideline**

Self-Paced Clinical Course


Practice Articles


**Question 6: Is low vision a primary diagnosis or a treatment diagnosis?**

**Answer:** Low vision is both a primary diagnosis and a treatment diagnosis. The cause of the vision impairment is secondary, and is never the primary diagnosis. This is an important distinction, and occupational therapy practitioners need to understand its significance for documentation and reimbursement.

**Question 7: What are some examples of intervention strategies for individuals with low vision?**

**Answer:** Common intervention strategies used to maximize independence and safety in desired occupations include the following:

- **Contrast Enhancement:** The visibility of objects can be improved by increasing contrast between the foreground and background. Optimal colors are black and white, but it is also helpful to use opposite colors on the color wheel. Examples of commercially available objects include high-contrast tape for edges of stairs or cabinets, signature or writing guides, measuring cups, and so forth.
• **Organizational Strategies:** Organization is key in assisting individuals with visual impairment to remain independent in desired occupations. Eliminating clutter and creating work stations decreases the potential for frustration.

• **Lighting:** Proper illumination is essential for the functional independence and safety of all older adults, but it is especially important for those with low vision. Lighting levels should be a minimum of 300 lux for general illumination and 750 to 1000 lux in reading areas (for additional information, please refer to Figueiro, 2001; IESNA, 1998). Using a gooseneck lamp is a great option as you can direct the light onto the reading surface.

• **Glare:** Increasing illumination without creating glare is important. The use of sheers or shades to filter light from windows will decrease glare. Using glare screens for computers or televisions, and wearing hats and sunglasses are other ways of managing glare.

• **Filters:** Using filters or sunglasses (prescribed by the optometrist or the physician) are ways of managing glare and controlling the amount of light that enters the eye. They can be used both indoors and outdoors.

• **Sensory Substitution:** For individuals who cannot rely on their vision, tactile or auditory substitution may enable safe participation in desired occupations. For example, applying bump dots to mark 350° F on the oven temperature dial will allow someone to set the temperature using their tactile sense. Other items may include talking glucometers, “say when” devices, talking watches, and so forth.

• **Magnification:**
  o **Relative Size Magnification:** Non-optical or large-print items (e.g., large-button telephone, clock, address book) can be used to compensate for a decline in visual acuity or central vision loss.
  o **Skills for Use of Optical Devices:** The application of prescribed optical devices (such as a prescribed magnifier) in activities of daily living requires the development of specific skills. Optical devices are utilized to enlarge the image, allowing the individual to more easily perceive a word or item. Magnifiers, telescopes, microscopes, and electronic magnification are common devices used to assist individuals with visual impairment to return to desired occupations. Minification: Optical devices can also be used to enhance visual field, for example, a reverse telescope can be used when the individual’s visual field is restricted.

• **Technology:** Many of the devices people use every day, such as cell phones, computers or tablets, have simple accessibility features that can improve access. In addition, there are thousands of applications that assist with identifying colors of clothing in the closet to assisting in reading labels in the grocery store.
Question 8: How do I become specialty certified in low vision?

Answer: AOTA has developed a peer-reviewed specialty certification in low vision to acknowledge specific skills in this specialized area of practice. The board and specialty certification process was developed from the AOTA standards of continuing competence (knowledge, critical reasoning, interpersonal skills, performance skills, and ethical reasoning).

Applicants must demonstrate how they have worked towards meeting established competencies and criteria through a reflective portfolio. Specifically, an individual must show how meeting these criteria has affected their practice and improved client outcomes. To begin the application process, go to Board and Specialty Certification at http://www.aota.org/Education-Careers/Advance-Career/Board-Specialty-Certifications.aspx. This is a reflective portfolio that normally takes several months or longer to complete.

References


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