

## VISUAL IMPAIRMENT SERVICES TEAM PROGRAM PROCEDURES

- 1. REASON FOR ISSUE.** This Veterans Health Administration (VHA) Handbook is issued to describe procedures related to the Visual Impairment Services Team (VIST) Program.
- 2. SUMMARY OF CONTENTS.** This new Handbook describes the scope of the VIST Program and procedures for providing outpatient VIST services in VHA medical facilities.
- 3. RELATED DIRECTIVES.** VHA Directive 1174 (to be published).
- 4. RESPONSIBLE OFFICE.** The Chief Consultant, Rehabilitation Services (117), with the office of Patient Care Services, is responsible for the contents of this VHA Handbook. Questions may be referred to the Director, Blind Rehabilitation Service at (202) 461-7355. Facsimile transmissions may be sent to (202) 495-5473
- 5. RECISSIONS.** VHA Manual M-2, Part XXIII, Chapters 2 and 3, are rescinded.
- 6. RECERTIFICATION.** This VHA Handbook is scheduled for re-certification on or before the last working day of November 2014.

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## VISUAL IMPAIRMENT SERVICES TEAM (VIST) PROGRAM PROCEDURES

### 1. PURPOSE

This Veterans Health Administration (VHA) Handbook defines Visual Impairment Services Team (VIST), and the procedures for the provision of services that fall within the purview of the VIST Program.

### 2. BACKGROUND

a. On February 8, 1967, the Department of Medicine and Surgery charged 71 field stations across the Nation with establishing coordinated outpatient services for eligible blind Veterans. Each facility was instructed to make contact with all blind Veterans within its jurisdiction and arrange for periodic reviews of their medical conditions and individual needs. The purpose of the program was to coordinate available resources to assist blind Veterans in maintaining satisfactory adjustments through the changing circumstances of life and advancing years.

b. In 1978, the Department of Veterans Affairs (VA) established six full-time VIST Coordinator positions in order to meet the growing demands of a Veteran population increasingly experiencing age-related vision loss. Over time, as the blind Veteran's population increased in numbers, additional VIST Coordinators were added, culminating in the comprehensive program that exists today.

### 3. DEFINITIONS

a. **Blind Rehabilitation Center (BRC)**. A BRC is a special organizational unit in a VA medical center which provides comprehensive and individualized rehabilitation programs for blind and visually impaired Veterans and active duty service members. An interdisciplinary team approach is used in a peer support environment. Team members focus their efforts on promoting health, developing skills of independence, and improving the blind Veteran's adjustment to sight loss with the ultimate goal of successfully reintegrating the individual into the family and community environment.

b. **Blind Rehabilitation Outpatient Specialist (BROS)**. A BROS is a multi-skilled, experienced, college or university trained blind rehabilitation specialist with a Bachelor's or Master's Degree in Blind Rehabilitation. The BROS is a specialist with advanced technical knowledge and competencies at the journeyman level in at least two of the following disciplines: orientation, mobility, living skills, vision rehabilitation therapy; visual skills, and low vision therapy. The BROS has been cross-trained to acquire broad-based knowledge in each of these disciplines, along with knowledge of manual skills and computer access training.

c. **Blind Rehabilitation Specialist (BRC Instructor)**. The position of Blind Rehabilitation Specialist refers to the BRC staff that assess, plan, and instruct in one of the BRC disciplines. It designates:

(1) An instructor with a Bachelors, Masters, or higher degree in one or more of the specialized areas of working with persons who are visually impaired.

(2) A professional who possesses a Bachelors, Masters, or higher Degree in an allied health profession who has expertise in one or more of the specialized areas of working with persons who are visually impaired.

d. **Computer Access Training (CAT)**. CAT is an instructional area that teaches the use of specialized access equipment necessary for a visually impaired person to independently operate personal computers. This includes evaluating and training the student to use large print, synthetic speech, and Braille access devices with personal computers in order to perform basic computer operations and maintenance.

e. **Continuum of Care**. The continuum of care consists of vision rehabilitation services, which range from basic outpatient low vision care provided by eye care professionals, to intermediate and advanced outpatient low vision care involving a team of eye care specialists and rehabilitation professionals, to outpatient blind rehabilitation services, and finally to inpatient blind rehabilitation services. Patients are referred to the type program that best matches their functional needs. The continuum of care in blind rehabilitation includes:

(1) Basic low vision care at every eye clinic in VHA.

(2) Intermediate low vision clinics in VHA that include the services of a low vision eye care specialist and a low vision therapist.

(3) Advanced hoptel low vision clinics that include the services of a low vision eye care specialist, a low vision therapist and an orientation and mobility specialist (Visual Impairment Centers To Optimize Remaining Sight (VICTORS) programs are an example of these clinics).

(4) Advanced ambulatory outpatient blind rehabilitation clinics that include the services of a low vision eye care specialist, a low vision therapist, orientation and mobility specialist and vision rehabilitation therapist. These programs have a supervisory chief and provide computer assisted training as a part of the blind and low vision rehabilitation services (Visual Impairment Services Outpatient Rehabilitation (VISOR) is an example of this type of program).

(5) Existing inpatient BRC programs, VIST Coordinators and BROS which provide the intensive services and case management required by legally-blind Veterans or Veterans who have excess disability because of visual impairment.

f. **Cross-Training**. Cross training refers to professional training that extends beyond an instructor's formal training, and is intended to maximize the instructor's area of expertise by combining specific instruction from other closely related disciplines. Cross-training is provided by instructors with verifiable competencies in the BRC Program disciplines of living skills, orientation and mobility, manual skills, visual skills, and computer access.

g. **Excess Disability.** Excess disability is characterized by problems and task performance difficulties related to vision loss that have a substantial impact on the person's functional independence or personal safety, and that are out of proportion to the degree of visual impairment as measured by visual acuities or visual fields. Veterans whose vision is better than legal blindness may have excess disability due to:

- (1) Sudden or traumatic visual disorder (especially related to military service).
- (2) Disabling co-morbidities (e.g., hearing impairment, mobility impairment, etc.);
- (3) Systemic diseases that cause fluctuating visual impairment;
- (4) Combined losses of other vision functions (e.g., contrast sensitivity, stereopsis, etc.);
- (5) Sudden changes in caregiver status; and
- (6) Other reasons.

h. **Hoptel Program.** The Hoptel Program is a hospital program in which patients are provided a hospital bed as an outpatient lodger rather than an inpatient. Patients receive safe, comfortable lodging, but do not receive medical care from physicians or nurses during their stay unless emergency care is required.

i. **Instruction (Basic).** Basic Instruction is introductory training, which addresses the skills used by visually impaired individuals for the management of everyday life tasks. These may include, but are not limited to:

- (1) Pre-cane skills, such as use of a human guide and independent protective techniques;
- (2) Self-care techniques, such as eating skills and personal grooming;
- (3) Health management, such as labeling medicines;
- (4) Activities of daily living (ADLs), such as telling time, dialing a telephone, identifying money, and the use of simple adaptive kitchen devices; and
- (5) Use of talking books.

j. **Instruction (Advanced).** Advanced instruction involves the sequencing of lessons that are designed to integrate and expand techniques taught during basic skill instruction in order to perform more complex tasks. Examples include, but are not limited to:

- (1) Business area travel, such as crossing streets with traffic lights and using public transportation;
- (2) Adaptive kitchen skills, such as hot meal preparation.

k. **Legal Blindness (Statutory Blindness).** Legal blindness exists when best corrected central visual acuity in the better-seeing eye is less than or equal to 20/200, or visual field dimension in the better-seeing eye is less than or equal to 20 degrees at the widest diameter, even if central visual acuity is better than 20/200.

l. **Licensed Eye Care Practitioner and Provider.** An optometrist or ophthalmologist is a licensed independent practitioner or provider who:

(1) Examines, diagnoses, treats, and prescribes medications, as well as optical and non-optical low vision devices; and

(2) Manages eye diseases and vision conditions within the providers her clinical privileges.

m. **Living Skills.** Living skills is the instructional area that focuses on communication skills and activities of daily living. These skills encompass a broad range of activities including personal grooming, eating skills, food preparation, and household management. Also included are communication skills such as Braille, keyboarding, handwriting, and reading with the use of electronic scanners.

n. **Low Vision.** A person is said to have low vision when vision is reduced from normal even with best spectacle correction; however, reduced vision is still functional for everyday tasks. Low vision can be enhanced through training visual skills, such as the use of optical low vision devices, the use of non-optical devices (such as lamps, large print, etc.), environmental modifications, and ergonomic enhancement.

o. **Low Vision Clinical Examination.** A low vision clinical examination is performed by a licensed eye care practitioner or provider. The examination provides the following:

(1) It determines the Veteran's level of visual impairment and current visual functioning;

(2) It provides for the best possible optical refractive correction; and

(3) It determines the patient's ability to benefit from adaptive vision training and prescription of optical low vision devices, as well as non-optical or electronic devices.

p. **Manual Skills.** Manual skills is the instructional area designed to enhance skills in sensory awareness with an emphasis on adaptive and safety techniques. Skills training focuses on organization, tactual awareness, spatial awareness, visual skills, memory sequencing, problem solving, and confidence building. Activities range from basic tasks using hand tools to advanced tasks using power tools and woodworking machinery.

q. **National Program Consultant.** National Program Consultants are professional field representatives of the Director of Blind Rehabilitation Service. Each Consultant provides ongoing support and consultative services to the VA BRCs and Clinics, BROS, and VISTs.

r. **Ocular Health Examination.** The ocular health examination is conducted by a licensed eye care practitioner or provider, who identifies the level of, and reasons for, a person's visual impairment.

(1) This examination includes:

(a) A refraction to establish best-corrected central visual acuities (not using a preferred retinal locus);

(b) A thorough assessment of the visual system and ocular health to establish the diagnosis primarily responsible for the impairment; and

(c) Ensuring that all ocular and visual disorders are being appropriately managed. If there is a significant visual field loss, a Goldmann Perimeter, or equivalent device, is used to determine the extent of the field loss according to the Veterans Benefits Administration (VBA) Fast Letter 06-21 on Measurement of Visual Fields.

(2) The examination provides the licensed eye care practitioner or provider with information essential to conducting or directing additional assessments and management strategies in order to deliver optimal visual impairment rehabilitative services.

s. **Optical Low Vision Devices.** Optical low vision devices alter the image focus, size (magnification or minification), contrast, brightness, color, or directionality of an object through the use of lenses or other technology.

(1) Such devices include, but are not limited to: habitual prescriptive spectacles (with or without tint), specialty contact lenses, microscopic spectacles, hand-held magnifiers, stand magnifiers, telescopes (monocular or binocular), head-borne lenses, minifiers, prisms, closed circuit televisions (CCTV), and electronic optical enhancement devices (EOEDs).

(2) These optical low vision devices must be prescribed by an appropriately credentialed and privileged optometrist or ophthalmologist.

t. **Orientation and Mobility (O&M).** O&M is the instructional area that addresses the establishment and maintenance of orientation to the environment and safe, efficient, and confident movement in that environment. In O&M, Veterans use all senses, available environmental information, and the use of protective techniques and devices.

u. **Preferred Practice Patterns.** Preferred Practice Patterns are guidelines for VIST coordinators and Blind Rehabilitation Specialists (including BROS) that specify procedures, clinical indications for performing the procedure, clinical processes, setting, equipment specifications, documentation aspects, and expected outcomes (see Blind Rehabilitation Service website: <http://vaww1.va.gov/blindrehab>). *NOTE: This is an internal VA Website not available to the public.*

v. **Visual Impairment Centers to Optimize Remaining Sight (VICTORS)**. VICTORS are examples of outpatient low vision clinical programs, which provide short-term low vision rehabilitation for visually impaired Veterans. There are currently four VICTORS programs which are located in Lake City, FL, Chicago, IL, Westport, NY, and Kansas City, MO.

w. **Visual Impairment Services Outpatient Rehabilitation (VISOR)**. VISOR is an example of an outpatient hospital blind rehabilitation center providing an abbreviated rehabilitation program. There are currently two VISOR programs, which are located in Lebanon, PA, and West Haven, CT.

x. **Visual Impairment Services Team (VIST)**. VIST is comprised of health care and allied health care professionals charged with the responsibility of ensuring that blind Veterans are identified, evaluated, and provided health and rehabilitation services to maximize adjustment to sight loss. Representatives may include, but are not limited to: social work, ophthalmology, optometry, prosthetics, primary care, vocational rehabilitation, library service, nursing, audiology, podiatry, nutrition, psychology, VBA), Blind Veterans' Consumer Organizations, blind consumers, and state or community agencies for persons who are blind.

y. **VIST Coordinator**. The VIST Coordinator serves as the case manager who has major responsibility for the coordination of services for visually impaired Veterans and their families, and is often the entry point into the continuum of care for visually impaired Veterans. Duties include:

(1) Arranging appropriate rehabilitation services and devices in order to enhance a visually impaired Veteran's functioning level (e.g., referrals to the VA's continuum of care as well as outsourced services in order to enhance the Veteran's functioning level).

(2) Identifying new cases of blindness;

(3) Providing professional counseling;

(4) Meeting specific objectives established by the VIST;

(5) Arranging VIST Reviews; and

(6) Conducting educational programs relating to VIST and blindness.

z. **VIST Annual Report**. The VIST Annual Report is an annual narrative completed by all VIST Coordinators and submitted to Blind Rehabilitation Service, VA Central Office, through local administrative channels. The report details program developments, program highlights, and program goals. A copy of the report is sent to the National Program Consultant responsible for the VIST designated area, and is due no later than October 31st of each year.

aa. **VIST Review**. In this review, the VIST Coordinator conducts an assessment of the Veteran's history, current skills level, adjustment to blindness, and needs. The VIST review includes:

(1) A comprehensive physical examination, ocular health examination, and audio logical examination, if deemed necessary.

(2) An assessment of patient history, current skill levels, adjustment to visual impairment, and needs.

(3) A description of the Veteran's functional capabilities and limitations. The VIST Coordinator develops a treatment plan which includes recommendations for other needed exams, services, and follow-up. **NOTE:** *When the VIST Coordinator utilizes reports from evaluations accomplished during the preceding year, this is called a "Component Annual Review."*

bb. **Visual Skills.** Visual skills training enables Veterans to gain a better understanding of their eye problems, and teaches them how to effectively utilize their remaining vision through techniques that improve visual perceptual and visual motor function. Visual skills training includes assessment and intervention with special low vision devices designed to meet the various needs of the person served. These needs may include, but are not limited to, reading, ADLs, orientation and mobility, and home repairs.

#### 4. SCOPE

a. The Blind Rehabilitation Service (BRS) VIST Program, which provides a continuum of care for blind Veterans. The team is a part of the dynamic BRS field element paradigm, which is comprised of the BRS National Program Consultants (NPCs), the inpatient BRCs, the outpatient blind rehabilitation clinics, the advanced and intermediate low vision clinics, and the BROSs. VISTs provide crucial services to blind Veterans that cover a broad range of needs.

b. The VIST and VIST Coordinators are most often the field elements responsible for initially identifying eligible blind Veterans, coordinating referral and transition to outpatient or inpatient rehabilitation programs both in VHA and the local community, and working closely with a BROS to coordinate care for the blind Veteran near the Veteran's home community. VISTs and VIST coordinators:

(1) Address the holistic needs of the blind Veterans whom they serve.

(2) Work closely with other VA programs such as Mental Health, Audiology, Physical Medicine and Rehabilitation, etc.

(3) Are responsive to the National Program Consultants, the Directors of BRCs, the Director of VA BRS, and officials of VA medical centers, while concomitantly maintaining attention to the changing needs of the blind Veterans they serve.

c. In addition, the VIST Coordinator:

(1) Promotes an individual's psycho-social adjustment to blindness that may require counseling, or referrals to appropriately qualified medical providers.

(2) Works with external federal, state, municipal, and private agencies to ensure that Veterans receive all services for which they are eligible.

(3) Is a patient advocate within the framework of VHA Blind Rehabilitation Service.

d. The VISTs utilize a team model to provide blind Veterans with services to address their housing, educational, employment, financial, rehabilitation, and physical health needs.

e. The VIST coordinators are the case managers who are ultimately responsible for the coordination and overview of all blind rehabilitation services, as they relate to each Veteran's individualized blind rehabilitation training needs.

## **5. RESPONSIBILITIES OF THE FACILITY DIRECTOR**

Every facility Director is responsible for:

a. Designating a facility VIST Coordinator and VIST Team.

b. Providing a full-time VIST Coordinator position, if the facility has 150 or more Veterans on the roster of the VIST Coordinator. This roster is maintained on the Blind Rehabilitation Service national database, and includes all Veterans who require blind rehabilitation services and who are case managed by the VIST Coordinator.

c. Assessing (in facilities with VIST rosters greater than 500 Veterans) whether the services described in this Handbook are adequately being provided to Veterans. These facilities are required to develop strategies for ensuring the demand for blind rehabilitation services are met at their centers.

(1) VA facilities must provide enhancements, to include adding a VIST assistant position or if indicated the creation of an additional VIST Coordinator position, in order to ensure that their Veterans' vision rehabilitation needs are being met. The National Program Consultant (NPC) of jurisdiction is a resource in deciding the best approach for service provision for the given area.

(2) All VIST programs need some measure of clerical support regardless of size to assist in necessary facility functions, such as time keeping, ordering office supplies, etc.

d. Establishing (in facilities with fewer than 150 Veterans on the VIST roster) a full-time VIST Program. A full-time program would increase outreach and accelerate the growth of services provided to visually impaired Veterans. If a facility operates a part-time VIST Program, the VIST Coordinator needs to devote at least 50 percent of their time to VIST duties. Part-time VIST Coordinators must be ensured of adequate time and support to fully perform all duties required to provide services to a blinded Veteran caseload.

e. Establishing a process to ensure that the VIST Coordinator is promptly notified of the admission of a blind Veteran.

f. Ensuring a local policy is published regarding the use of guide dogs by blind inpatients.

g. Encouraging and supporting involvement by state and community blindness agencies, consumer groups, and Veterans Service Organizations (e.g., Blinded Veterans Association) in services for visually impaired Veterans.

***NOTE:** Full-time and part-time VIST Coordinator roster size thresholds are based on the following rationale: the average full-time VIST Coordinator can feasibly conduct a maximum of 10 comprehensive 2-hour annual reviews per week for a maximum yearly total of 500 annual reviews. This activity would account for approximately half of a full-time VIST Coordinator's workload annually. The other half of full-time VIST Coordinator's time is typically dedicated to: documentation, development, and referral of new cases; coordination of prosthetic order; ad hoc Veteran issues, staff education; community outreach; and other duties and responsibilities detailed in this Handbook. A part time (0.5 FTE) VIST Coordinator would be expected to accomplish half of what a full-time VIST Coordinator achieves annually, as detailed in this Handbook.*

## **6. RESPONSIBILITIES OF THE VIST**

The VIST at each facility must be interdisciplinary in nature, and as a whole, is responsible for:

a. Determining and delivering the comprehensive services required by blinded Veterans. The team is composed of, but not limited to, the following members:

(1) VIST Chairperson. The chairperson is elected by team members. The VIST Coordinator may serve as the VIST Chairperson. The Chairperson is responsible for conducting regular VIST meetings.

(2) VIST Coordinator.

(3) BROS (if available).

(4) Other Team Members. The team is comprised of professionals representing other services that impact the care of blind Veterans. Team members serve as consultants to VIST in their areas of expertise. Members may include, but are not limited to representatives from: Social Work, Ophthalmology, Optometry, Prosthetics, Primary Care, Rehabilitation, Library, Nursing, Audiology, Podiatry, Nutrition, Psychology, Patient Administration, and Financial Services. VBA, Blind Veterans' Consumer Organizations, blind consumers, and State or community agencies for the blind may also be represented.

b. Meetings annually at a minimum. Additional meetings may be called as necessary, and may be held either in person, using e-mail, or by audio or video conferencing. The VIST Coordinator must record minutes of the proceedings and disseminate them to team members and VA management.

## 7. RESPONSIBILITIES OF THE VIST COORDINATOR

The VIST Coordinator is responsible for:

a. **Outreach and Education.** Outreach and Education includes:

(1) Developing a cache of educational materials, in a variety of media that can be utilized to help achieve VIST outreach goals and objectives;

(2) Providing in-service educational classes for VA and non-VA agencies and personnel;

(3) Seeking to improve others' awareness with regard to blindness issues. *NOTE: These outreach activities serve to increase overall support for BRS services, and improve VA and non-VA referrals to the local VIST program. Many of these referrals to VIST may then result in referrals to BRCs, BROS, and other VA visual impairment clinicians.*

(4) Utilizing developed methodologies to identify Veterans who are eligible for VIST program services, to include identifying blind Veterans from VA medical center diagnosis codes entered in their electronic medical record; and

(5) Educating VA medical center staff on the functional implications of vision loss and on blind rehabilitation matters.

b. **Case Management.** VIST Coordinators are case managers for all eligible Veterans who have visual impairments requiring blind rehabilitation services. Veterans with low vision who are not legally blind are referred to VIST when excess disability can no longer be managed solely by low vision services. Eligible Veterans include those who are legally blind and those who are not legally blind but whose vision-related functional disability is so severe that they require case management and blind rehabilitation. Other duties include:

(1) The coordination and overview of all of the Veteran's blind rehabilitation needs. *NOTE: VIST program Veterans are offered lifetime case management.*

(2) Determining the intensity of services based upon clinical judgment and the Veteran's goals. *NOTE: When serving Veterans of Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF), VIST Coordinators work in close cooperation with all VHA OEF/OIF case management personnel and comply with all VHA Directives related to OEF/OIF case management services. When a VIST Coordinator is assigned to an OEF/OIF service member as a primary case manager, the VIST Coordinator must follow guidelines established by VHA Handbook 1010.01, and local facility policy. When there is a BROS stationed within the VIST's geographical area of responsibility, the VIST Coordinator and BROS work cooperatively to maximize all aspects of the Veteran's treatment program. This may include referrals to BRCs, BROS, VA and non-VA agencies, and all professional referrals that support the VIST Coordinator's holistic approach to optimizing the independence, health, and welfare of blind and visually impaired Veterans.*

(3) Flagging VIST eligible Veterans' patient records so that medical center staff who access patients' records electronically are alerted to the Veteran's visual status.

c. **Assessment, Treatment Planning, Referral, and Follow-up.** This includes:

(1) Performing assessments to establish Veterans' needs as they relate to the continuum of vision treatment services.

(a) Veterans are assessed according to a wide range of specific health, independence, and lifestyle variables.

(b) VIST assessments may be completed in the medical center or in the Veteran's home.

(c) VIST assessments may be part of an interdisciplinary assessment.

(d) These comprehensive assessments will allow the VIST coordinator and the treatment team to develop a clear picture of the Veteran's vision loss and functional deficits and the resultant individual rehabilitation needs.

(e) VIST assessments may be performed annually once the Veteran is on the VIST services roster.

(f) VIST Coordinators may conduct follow up assessments by telephone concurrent with a full review of available electronic medical records.

(2) Referring Veterans to the appropriate service component in the continuum of care where services will be provided. The service model for the provision of care to visually impaired Veterans is flexible and responsive to the changing visual needs of visually impaired Veterans (see App. A). Regardless of the service within this algorithm (See App A) through which Veterans enter into the vision services model, VIST Coordinators play a critical role by lending their professional insight, and by providing overview while performing follow-up evaluations.

(3) Developing focused treatment plans containing goals to meet the Veterans' needs.

(a) The plans are designed to ensure that Veterans receive the appropriate care at the right time, and in the best setting to maximize service delivery performance as it pertains to an individuals' needs. When a VIST Coordinator refers a Veteran for blind rehabilitation by VHA staff, they are involved with the blind rehabilitation providers in both blind rehabilitation treatment planning and discharge planning. The VIST Coordinator is instrumental in treatment planning when a contracted vendor or community agency provides rehabilitation services to a Veteran.

(b) The Veteran's blind rehabilitation needs may be best addressed by an appropriately credentialed and privileged licensed eye care practitioner provider, and Blind Rehabilitation Specialists in a local facility in a continuum of care outpatient low-vision or blind rehabilitation clinic; in a comprehensive BRC; or through community based services. Based on the Veteran's

treatment plan, the VIST Coordinator may refer the Veteran to one or a combination of these programs.

(c) The goal of the treatment plan is to maximize the overall benefit to the Veteran in order that the Veteran is returned to the highest level of independence, with the greatest improvement in their quality of life.

(d) Co-morbidities may play a part in determining the most appropriate training setting for the Veteran, as will the Veteran's current professional, educational, and family status. The BRCs are best suited to providing a highly concentrated, comprehensive, and integrated blind rehabilitation training program. The BRCs also offer the framework for a therapeutic dynamic among the Veterans who are attending the BRC at the same time. The Veterans assist each other in direct and indirect ways, sharing their blind rehabilitation experience with their fellow blind Veterans which can result in improved adjustment to blindness. In addition, the BRCs may provide Family Training Programs (FTP) for the Veteran's spouse or family member toward the end of the treatment process. FTPs serve to improve the participant's understanding of the Veteran's newly developed skill sets, as they relate to the Veteran's reintegration back into their home environment.

(e) The needs of some Veterans can be met by the short-term programs, such as the intermediate or advanced low vision care clinics, or outpatient hoptel blind rehabilitation clinics. For other Veterans, services by BROS may be sufficient to meet their limited rehabilitation needs or supplement the services of other field elements.

(4) Providing follow-up for rehabilitation services that the Veteran has received. The VIST Coordinator must assess and monitor the Veteran for any blind rehabilitation needs. The initial assessment must be done within 30 days of the completion of the rehabilitation program.

d. **Development, Implementation, and Oversight of Special Program Services.** VIST coordinators may be encouraged by the Director of VA BRS, through the NPCs, to develop and implement special VIST local program services. The local CAT programs are an example of this type of program development and implementation. VISTs may share some responsibilities for the operation of these programs with a BROS, but the VIST Coordinator is ultimately responsible for the oversight of these programs. VIST offices remain flexible and responsive to the development of new programs that may come from VA BRS central office in the future.

e. **Responsibilities Toward BRS Field Elements.** The VIST Coordinators must maintain effective communication with all of the BRS field elements (NPCs, BRCs, BROS, other VISTs) to maximize Veterans' blind rehabilitation outcomes. VIST coordinators must:

(1) Maintain an open dialogue with BRC Directors and BRC staff, and be flexible to the changing needs of the overall BRS service delivery system;

(2) Be responsive to the input of the NPCs who are responsible for support and evaluation of VISTs;

(3) Contribute their professional knowledge in support of BRS program goals and objectives, through the NPCs; and

(4) Work in close cooperation with BROS, sharing information on Veterans and working cooperatively in all elements of service delivery.

f. **Benefits Review.** The VIST Coordinator provides eligible Veterans on the VIST roster with an initial benefits review, and subsequent annual benefits reviews thereafter. The VIST coordinator must be knowledgeable with respect to all VA and non-VA benefits that may serve to enhance the lives of qualified Veterans. Additionally, the VIST Coordinator may assist Veterans in initiating action to apply for benefits. VIST Coordinators are also aware of Veterans Service Organizations that assist Veterans with regard to the acquisition of benefits, and the VIST Coordinator may refer a Veteran to one or more of these agencies. Benefits Reviews may include, but are not limited the following typical areas:

(1) VA benefits and services, which include:

(a) VA Compensation and Pension benefits;

(b) Automobile grants;

(c) Special housing adaptation grants (see Title 38 United states Code (U.S.C.) Section 2101a, and 38 U.S.C. Section 2101b);

(d) Home Improvement and Structural Alteration (HISA) Program;

(e) VA health care programs;

(f) Vocational rehabilitation and education;

(g) Commissary and Post Exchange privileges;

(h) Death and burial benefits;

(i) Prosthetic and sensory aid equipment;

(j) VA blind and low vision rehabilitation programs, such as intermediate or advanced low vision care clinics, VICTORS programs, outpatient hoptel blind rehabilitation or VISOR programs, and BRCs; and

(k) State Veterans' benefits.

(2) Non-VA benefits and services, which include but are not limited to:

(a) Income tax exemption;

- (b) Property tax exemption;
- (c) Community blind and low vision rehabilitation;
- (d) State and community benefits and services;
- (e) Hadley School for the Blind;
- (f) Blinded Veterans Association;
- (g) Consumer groups for the blind;
- (h) National Parks Pass Program;
- (i) Talking books program;
- (j) Radio Reading Service;
- (k) Social Security Administration (SSA); and
- (l) Handicapped parking permits.

g. **Veteran and Family Education and Counseling.** The VIST Coordinator assists the Veteran and their family members with the issues surrounding the emotional adjustment aspects of blindness. The VIST and VIST Coordinator may draw on their own professional expertise to personally assist the Veteran and the Veteran's family members in this process, or the VIST Coordinator may make a referral to an appropriate clinician to assist.

h. **Prosthetic Recommendation and Issuance.** The VIST Coordinator may recommend issuance of prosthetic equipment for blind and visually impaired Veterans in accordance with VHA policies. If the issuance of a prosthetic item is deemed appropriate and subsequently approved, then the VIST Coordinator may request authorization of funds with the intent of utilizing professionally qualified personnel to train the Veteran with this prosthetic device.

- (1) These prosthetic devices are issued in accordance with the following:
  - (a) VA Handbook 1173.5, Aids for the Blind.
  - (b) VA Handbook 1173.2, Furnishing Prosthetic Appliances and Services.
  - (c) VHA Handbook 1173.12, Prescription Optics and Low-Vision Devices.
  - (d) VHA policies on Prescribing Hearing Aids and Eyeglasses.

(e) VHA Prosthetics Clinical Management Program (PCMP) Clinical Practice Recommendations policies pertaining to issuance, prescription, and provision of prosthetics for visually impaired Veterans that include the documented provision of an appropriate level of training in the use of devices.

1. VHA PCMP Clinical Practice Recommendations on Prescription and Provision of Optical Low-Vision Devices to Aid in Overcoming Visual Impairment.

2. VHA PCMP Clinical Practice Recommendations for Prescription of CCTVs and Other Electronic Optical Enhancement Devices (EOED).

3. VHA PCMP Clinical Practice Recommendations for Prescription and Provision of Daily Living and Mobility Devices for Legally Blind and Visually-impaired Veterans.

4. VHA PCMP Clinical Practice Recommendations for Audible Prescription Reading Devices.

5. Other policies listed on the Prosthetics and Clinical Logistics Office website at <http://vaww.pclo.med.va.gov>

(f) Existing national contract guidelines on Aids for the Blind.

(2) Issuance Procedures. Candidates must demonstrate the ability to utilize the equipment for the identified needs. Required documentation includes identification of need, training provided, and the capability of the Veteran to utilize the equipment.

(a) Aids and devices for the blind may be issued by VIST Coordinators provided the following conditions are met:

1. Optical low vision devices are prescribed by an appropriately credentialed and privileged optometrist or ophthalmologist.

2. All other prosthetic devices must be provided by an appropriately credentialed and privileged health care provider.

3. The Veteran has a stated need for the device.

4. The Veteran must demonstrate the ability to use the device correctly.

(b) Issuance of a device is to be based on demonstrated proficiency and ability to safely and independently use the device. The issuance of a device must follow nationally-established guidelines for issuance and must include written justification of need, training provided, and the capability of the Veteran to utilize the equipment.

(c) The VIST Coordinator reviews the Veteran's request and determines the Veteran's need for the equipment as well as the Veteran's potential to successfully learn to use the equipment.

(d) The VIST Coordinator, in consultation with the VIST and continuum of care programs when appropriate, determine the most appropriate place for further evaluation or training in the use of the device. The request may be handled locally, either directly through VIST, BROS, or with assistance from a qualified community resource.

(e) Training needs to be conducted in the least restrictive environment available to the Veteran, depending on the availability of appropriate, quality local resources for the blind. If the training cannot be provided locally or the Veteran requests training at a BRC program, VIST is to refer the Veteran to the BRC of jurisdiction. When training is required, the training must be provided by an individual with appropriate competencies to instruct the Veterans in the proper use of that device. **NOTE:** *Evaluation and training needs to be provided by qualified blind and vision rehabilitation professionals.*

(f) Home setup of equipment. Veterans may require assistance with home setup of some types of electronic equipment. Although independent set-up of equipment is desirable and needs to be part of training, setup may be indicated due to a Veteran's physical limitations. If setup is necessary, the process requires coordination among the VIST Coordinator, local vendors, BRC, Prosthetic and Sensory Aids Service, and the Veteran. **NOTE:** *In order to ensure that setup occurs in a timely manner, planning should begin as soon as it is determined that setup will be required.*

i. **Documentation.** The VIST Coordinator is responsible for documenting all VIST activities as they relate to the aforementioned scope of services in the BRS National Database. Documentation must be consistent with all applicable VHA policies, Handbooks, and Directives. Workload data (i.e., encounter codes and Decision Support System (DSS) information) are entered into the electronic medical record according to local medical facility policy using the appropriate stop codes. The VIST Coordinator must enter a progress note into the electronic medical record following each patient encounter. As appropriate, the progress note will address the purpose of the patient's visit to the VIST office (or telephone encounter), the identification of the Veteran's newly identified needs, the treatment plan that addresses those needs, the actions taken toward achieving the goals and objectives of the treatment plan, and the eventual evaluation of the level of achievement with relation to the identified needs. VIST Coordinators must also submit an annual narrative. The annual narrative details program developments, program highlights and program goals for the period of October 1 – September 30, and is due in VA Central Office no later than October 31<sup>st</sup> of each year.

j. **Administrative Services.** The VIST Coordinator is responsible for:

- (1) Monitoring and assisting in updating policy and procedures related to blind Veterans;
- (2) Assisting in developing hospital policy pertinent to blindness;
- (3) Developing service agreements;
- (4) Resolving issues about blindness that cross service and department lines;

- (5) Implementing quality monitors;
- (6) Responding to compliance issues; and
- (7) Meeting standards for The Joint Commissions and CARF reviews.

## 8. VIST COORDINATOR PROFESSIONAL DEVELOPMENT

The BRS must provide professional education and training programs to update VIST Coordinators on the latest developments in the field of blind rehabilitation. Training must be provided or coordinated by the BRS National Program Consultants. In addition, VIST Coordinators are expected to take advantage of local training opportunities, which contribute to their professional competencies. VIST Coordinators are encouraged to attend all BRS sponsored national training programs as part of this professional development agenda. *NOTE: VA medical centers are encouraged to support the VIST Coordinator's attendance at national events.*

## 9. ELIGIBILITY FOR VIST SERVICES

BRS is committed to serving all eligible Veterans and active duty personnel who need and can benefit from its unique services. Legal blindness based on measurement of visual acuity and visual fields have long been recognized as indicators of disability and continue to be a primary test of eligibility. However, because of the complex relationship between visual function and the overall functional capacity of the individual, eligibility criteria for blind rehabilitation services must address functional deficits and the rehabilitation needs of the person. In order for a person to be eligible for VIST services, the Veteran must be enrolled in VA health care and meet one of the following criteria:

- a. Best corrected central visual acuity in the better-seeing eye is less than or equal to 20/200, or visual field dimension in the better-seeing eye is less than or equal to 20 degrees at the widest diameter, even if central visual acuity is better than 20/200.
- b. Due to excess disability, comprehensive treatment is needed for appropriate restoration of the individual's safety or functional independence or for establishment of their personal or social adjustment to vision loss.

## 10. SUPPORTIVE SERVICES

a. **Social Work Service.** A Social Worker may be assigned as a VIST member if the VIST Coordinator is not a qualified social worker. The Social Worker provides a comprehensive psychosocial assessment, psychosocial treatment, and discharge planning when indicated.

b. **Ophthalmology or Optometry Service.** Ophthalmology Service or Optometry Service provides ocular health examinations, low vision clinical examinations, treatment and management of ocular diseases and vision disorders as appropriate, and determination of visual function. Ophthalmologists and Optometrists must prescribe all optical low vision devices and

may provide instruction in their use. The VIST Coordinator and eye care staff work cooperatively to ensure that Veterans receive appropriate vision rehabilitation services.

c. **Prosthetic and Sensory Aid Service (PSAS)**. PSAS provides prosthetic equipment and services appropriate to the needs of visually impaired clients, and maintain sufficient stock to ensure prompt availability.

d. **Primary Care and Ambulatory Care Service**. Medical staff assigned to the VIST provide documentation of current medical status to support referrals for blind rehabilitation services and annual VIST Reviews. They also conduct annual History and Physical (H&P) exams for those VIST Veterans who are not treated by VA primary care teams.

e. **Library Service**. Library Service needs to work closely with the Library of Congress National Library for the Blind, and physically handicapped network libraries to obtain talking books and players. Electronic print magnification systems need to be available to allow visually impaired patients to access normal print materials. The patients' library must have a collection of reading materials and adaptive equipment to ensure that visually impaired patients have appropriate access to library information. This includes recreational reading materials and reference materials in accessible format and the equipment to support these materials. There needs to be an ample supply of large print materials.

f. **Nursing Service**. Nursing Service assists in the identification and referral of visually impaired Veterans to the VIST Program. Additionally, nursing staff may be involved in training patients and family members to use specialized medical equipment for the blind. VIST conducts educational programs for local nursing staff on the special nursing-related and adaptive technology needs of blind patients.

g. **Audiology and Speech Pathology**. Audiology and Speech Pathology Service ensures that visually impaired Veterans receive audiological examinations and hearing aid evaluations as indicated, as part of their annual VIST reviews. In certain cases, an up-to-date audiological exam and the provision of hearing aids, speech and language therapy, or other services may be required before a Veteran is admitted for inpatient blind rehabilitation services at a BRC.

h. **Physical Medicine and Rehabilitation Service (PM&RS)**. PM&RS staff serve on the VIST when needed, and provide appropriate treatment and consultation to support the unique needs of visually impaired Veterans.

i. **Podiatry Service**. Visually impaired clients often are not capable of independent foot care. Podiatry Service provides podiatric examinations, treatment, and equipment for VIST eligible blind clients who need this service. This service is especially important for diabetic blind Veterans.

j. **Nutrition Service**. Nutrition Service may provide screening, education, and nutrition counseling regarding nutrition to blind clients, as needed.

k. **VA Regional Office Representatives**. VA's Regional Office Representative in each VISN, must assign an adjudication staff member to act as a VIST liaison for consultation

purposes, and to expedite benefits claims, when appropriate. A Veterans Benefits Counselor evaluates and counsels individual blind Veterans and their dependents regarding eligibility for VA and other government benefits. VA Regional Office Vocational Rehabilitation (VR) and Education Service staff may serve as, VIST representatives or consultants for those blind Veterans who might benefit from their services.

l. **Specialty Case Managers.** VHA has several specialty programs that utilize case management as part of their practice such as: (1) Chronically Mentally Ill (CMI); (2) Spinal Cord Injury (SCI); (3) Polytrauma; (4) OEF-OIF Program; and (5) Home Based Primary Care. The VIST Coordinator needs to work with the other specialty case managers to coordinate a care plan. In some cases, the VIST Coordinator is the primary case manager, while in other cases the VIST Coordinator co-case manages the Veteran's care.

m. **Pharmacy Service.** VIST Coordinators partner with Pharmacy Service for medication issues that are specific for blind Veterans.

## **11. LIFETIME CASE MANAGEMENT MODEL FOR VIST ENROLLED VETERANS.**

The VIST Program is a model of lifetime case management offered to all Veterans enrolled. Each case is unique. VIST Coordinators must use their best judgment in providing case management within the continuum of care. The continuum requires varying degrees of intervention to include intensive, progressive, and supportive phases based on the clinical and psychosocial presentation of each individual patient. As Veteran adjustment to blindness or rehabilitation goals are met, intensive case management services may not be required, reducing the number of necessary contacts with the VIST Coordinator. However, more intensive case management may be required for patients who experience significant life changes. There are four levels of VIST Case management: Intensive, Progressive, Supportive, and Lifetime.

a. **Intensive BRS Case Management: Contact Monthly.** Veterans are often referred to VIST Coordinators because they experience a problem that impedes their ability to manage and accomplish functional tasks. At this stage, life-threatening medical conditions have typically been addressed, and the Veteran is able to participate in some level of rehabilitation. Home visits may be needed during this phase. A thorough assessment is needed to plan the intervention and rehabilitation goals with the Veteran and family. Crisis intervention may be needed if the change is stressful. Education and support for the Veteran's support system is very important during this phase, which usually occurs at times of transition that includes:

(1) Transfer of care to a new VA Medical Center;

(2) Patient or family relocation;

(3) Referrals to programs (e.g., Day Treatment, Compensated Work Therapy, community re-entry program);

(4) Change in social support system (e.g. caregiver stress, divorce, decline in support system, death of a family member, loss of job, new employment);

- (5) Newly identified mental health problems (e.g., depression, Post Traumatic Stress Disorder (PTSD), substance abuse) and behavioral changes;
- (6) Significant change in medical status and functional decline;
- (7) Change in living arrangements, such as admission to assisted living or a skilled nursing facility; and
- (8) Transfer to another facility for blind or low vision services (inpatient BRC or hoptel outpatient BRC or low vision clinic).

***NOTE:** At this level of care, the Veteran's case is reviewed and documented in the BRS database and Computerized Patient Record System (CPRS) with a VIST summary only. Depending on the circumstances, the length of time the Veteran is kept in this level of care from the initial enrollment (activation in the local VA) varies on a case-by-case basis and is dependent upon the goals and objectives established with the Veteran.*

b. **Progressive BRS Case Management: Contact Quarterly.** This level of care reflects a transition to a quarterly follow-up, at a minimum. This level of care needs to be implemented at the point that the individual no longer warrants Intensive Case Management. This phase occurs when a support system is in place and the patient is medically stable but still requires ongoing intervention to address specific visual impairment issues. There needs to be defined goals and objectives such as enrollment in classes for college, supportive counseling for family once every 3 months, etc. The patient may need supportive counseling, assistance with obtaining resources, advocacy, and education. Family support remains important.

- (1) Examples of issues that may require case management during this phase include:
  - (a) Monitoring progress on referrals made to VBA;
  - (b) Assisting with accessing VR services;
  - (c) Referring to community agencies and resources;
  - (d) Facilitating community re-entry;
  - (e) Applying for home modifications;
  - (f) Counseling for adjustment issues; and
  - (g) Ensuring access and coordination of care.
- (2) Documentation for this level of care needs to include a VIST summary for the BRS Database and CPRS.

c. **Supportive Case Management: Contact Semi-Annually.** This level of care needs to be implemented at the point that the individual no longer warrants Progressive Case Management. This phase may consist of an in-person or telephone follow-up with the patient and family.

(1) The supportive phase is appropriate for:

(a) Patients well established in the BRS System of Care with stable medical, psychosocial, and visual impairment issues;

(b) Ongoing issues related to BRS, such as replacement of visual impairment equipment; and

(c) Completing previous goals established in earlier phases of rehabilitation

(2) Documentation for this level of care needs to include a VIST summary for the BRS Database and CPRS.

d. **Lifetime Case Management: Annual Review.**

(1) This level of care reflects on-going follow-up and review which may be completed annually or bi-annually depending upon the Veteran's goals. The Veteran may decline this review. This level of care should be implemented at the point that the individual no longer warrants Supportive Case Management, and may extend for the remainder of the Veteran's life if the Veteran accepts.

(2) A review in this stage consists of:

(a) Verifying a Veteran's status;

(b) Assessing a Veteran's continued adjustment to blindness;

(c) Reviewing benefits and services; and

(d) Reviewing current needs and goals.

(3) The Veteran needs to be referred annually for an ocular health examination, physical examination, and an audiological examination, if required.

**NOTE:** All reviews must include either a psychosocial assessment or a VIST assessment, completed after a VIST interview. Reviews must include a treatment plan. The VIST Coordinator must document the Veteran's participation in both the CPRS medical record and in the BRS national database. At any time, a service member may request not to continue with treatment plans. If this occurs, VIST are expected to document in both the CPRS and BRS database.

## 12. BRC ELIGIBILITY

a. In order for a person to be eligible for admission to a BRC Program, the person must be eligible for VA health care and meet one of the following criteria:

(1) Best corrected central visual acuity in the better-seeing eye less than or equal to 20/200, or visual field dimension in the better-seeing eye less than or equal to 20 degrees at the widest diameter, even if central visual acuity is better than 20/200; or

(2) Comprehensive treatment due to excess disability is needed at a BRC for appropriate restoration of the individual's safety or functional independence, or for establishment of their personal or social adjustment to vision loss. If needs are such that they cannot be appropriately addressed by local components of the VHA continuum of care, admission to a BRC is authorized.

b. The following information is required with a Veteran's referral:

(1) An assessment providing a comprehensive description of functional deficits and personal adjustment problems related to vision that includes the results of the ocular health examination and any low vision clinical examination by a licensed eye care practitioner or provider;

(2) Information that local services within the continuum of care are not available, or are unable to adequately address the Veteran's blind rehabilitation needs; and

(3) Concurrence by the VIST.

*NOTE: If the referral source and the BRC do not agree on the need for BRC admission, the application must be forwarded to the Director, BRS, for review.*

c. For active duty military personnel, a summary report must be requested from the referral source describing the individual's vision related functional or adjustment problems that includes the results of the ocular health examination and any low vision clinical examination by a licensed eye care practitioner or provider.

d. Veterans or active duty service members may be referred to BRCs for their regular program, computer access training only, or dual programs that include comprehensive training and computer training.

## 13. PRIORITY OF CARE IN A BRC

a. Priority of care is provided to active duty military personnel, service-connected Veterans rated 50 percent or greater for any combination of disabilities, and Veterans who are service connected for their visual impairment.

b. The priority for admission considers urgent need factors, such as:

- (1) Safety issue;
- (2) Medical issues;
- (3) Lack of a caregiver;
- (4) Vocational needs (e.g., attending school, employed);
- (5) Active duty status;
- (6) Never attended a BRC, and
- (7) Direct patient transfer.

c. In lieu of these priority circumstances, the BRC normally offers an admission date based on the date an approved application was received.

d. If an admission is needed in order to maintain bed census, the BRC may give priority to Veterans who are willing to be admitted on short notice.

#### **14. BRC REFERRALS**

a. **Catchment Areas.** The relatively small number of blind Veterans in communities dictates that the delivery of services to blind Veterans must operate on a regional system of blind rehabilitation programs. Catchment areas are established by the Director, BRS, in consultation with the BRC Chiefs and affected VISN Directors.

(1) To support effective communication and cooperative treatment planning between VISTs and BRC staff, most Veteran referrals need to conform to assigned catchment areas. To accommodate the personal needs of Veterans, VIST coordinators may refer individual Veterans to BRCs outside the assigned catchment areas with the approval of the Chiefs of affected BRCs. Applications may not be sent to more than one BRC for admission.

(2) All Veteran referrals for admission to a BRC program must be submitted by a VIST Coordinator through the Blind Rehabilitation Version 5.0 (BR V5.0) database using the defined referral procedures. At VA Polytrauma Rehabilitation Centers and Network Sites, VIST Coordinators coordinate applications with the Case Manager.

(3) Blind Veterans and military personnel may benefit in varying degrees from a comprehensive blind rehabilitation program, despite limitations caused by other physical or mental problems. They need to be referred when they have the potential to benefit from the program despite their limitations. When questions arise about the appropriateness of a referral for BRC training, the referral source needs to consult directly with the BRC for guidance.

(4) The presence of complicating medical or mental conditions does not preclude Veterans or military personnel from participating in the blind rehabilitation program. To maximize benefit from the program, specific conditions that may adversely affect patient involvement (e.g., acute medical conditions, stroke residuals, alcohol or drug abuse, amputation with planned prosthesis, need for assistive listening devices, etc.) needs to be addressed by the referring facility before admission to the BRC. Referral to the most appropriate BRC setting may be considered in consultation with the affected BRCs. Blind Veterans and military personnel who are hospitalized, may be transferred directly to a BRC when transfer is medically indicated, and when they are able to participate in the BRC Program.

(5) The Chief, BRC, has final authority to determine acceptability of applicants. Before doing so, input may be required from appropriate health care professionals (e.g., physician, psychologist, optometrist, nursing, etc.) regarding conditions that potentially impact the Veteran's health capacity and rehabilitation.

b. Referrals of Active Duty Personnel and Polytrauma Veterans

(1) Referrals of active duty military personnel and patients at VA Polytrauma Rehabilitation Centers, Polytrauma Rehabilitation Polytrauma Network Sites as well as other locations within the Polytrauma System of Care must be determined by the potential patients personal needs and preferences and by their medical support requirements, without regard to BRC catchment areas.

(2) Referrals of active duty military personnel must be submitted by program case managers at Military Treatment Facilities or Polytrauma Rehabilitation Centers, and must follow the procedures outlined in the current Memorandum of Agreement established by VA and Department of Defense (DOD). **NOTE:** *VIST Coordinators assist as needed.*

c. Procedures. During attendance at a BRC program, a blinded Veteran is considered to be an inpatient of the VA facility. As such, application criteria and management are generally the same as for any Veteran receiving inpatient hospital treatment and care. The VIST Coordinator will refer all Veterans for blind rehabilitation center training to the BRC of jurisdiction via the Blind Rehabilitation National Database. The application procedures must be followed in accordance with VHA policies:

(a) The Veteran's patient record must be completed and include the title and dates of the progress notes and other medical documentation that supports the referral in the BR 5.0 patient record. Supporting documentation must be current (within 6 months of referral date) and include the following:

1. Any necessary eligibility determinations as required by the VA facility housing the BRC (e.g., VA Form 10-10, VA Form 10-10F, Hospital Inquiry (HINQ), Rating Decision Form).

2. Documentation of severe functional visual impairment signed by an appropriately credentialed and privileged health care practitioner, and documentation of visual impairment or legal blindness signed by a licensed eye care practitioner or provider that includes the following:

- a. The diagnosis responsible for the vision loss;
          - b. The best corrected central visual acuity of each eye; and
          - c. The visual field of each eye.
        3. A physical examination and history from or performed by a Physicians Assistant under the supervision of a credentialed and privileged health care provider detailing:
          - a. All medical conditions that may affect progress in the rehabilitation program;
          - b. Pertinent laboratory reports (e.g., Complete Blood Count (CBC) with differential, Chem 7, urinalysis);
          - c. Current medications (if applicable, include current oxygen prescription and the provider of oxygen delivery equipment);
          - d. A negative Purified Protein Derivative (PPD) test (if positive, a Chest X-ray is required), Electrocardiogram (EKG), and past medical reports when appropriate (as determined by Primary Care Medical Provider); and
          - e. A statement of medical stability by the Primary Care Medical Provider, as it relates to the Veteran's capacity to participate in the BRC Program.
        4. When applicable, assessments from other consultative services that provide a description of the level of independence or assistance needed in ADLs, such as:
          - a. Wound care.
          - b. Tracheotomy care.
          - c. Stoma or ostomy care.
          - d. Wheelchair transfers.
          - e. Oxygen use.
          - f. Medication management.
          - g. Personal hygiene.
- (b) Referrals with pending audiology exams may be submitted, but audiology issues must be resolved within 90 calendar days or the application will be considered incomplete and returned to the VIST Coordinator.

(c) A psychiatric or psychological report if there is a history of central nervous system dysfunction, psychiatric diagnosis (including substance abuse), or any active treatment for a mental or emotional condition.

(d) An applicant with demonstrated alcohol or substance abuse or dependence (current or recent) requires individualized assessment by a mental health care professional to determine whether the applicant is able to benefit from blind rehabilitation. In cases of suspected alcohol or substance abuse or dependence, the psychologist must utilize clinical judgment and may request that a substance abuse evaluation be conducted by a mental health care professional. Issues such as depression, sleep disorder, seizure, etc., can be successfully managed prior to admission and may require ongoing management in the BRC.

(e) A VIST assessment and psycho-social report which includes the Veteran's expressed needs and goals, functional capabilities, as well as a description of any previous VA and non-VA blind rehabilitation training. This VIST report needs to contain other information as defined in the VIST Handbook.

(f) If the Veteran has been evaluated and trained by a BROS or other specialist in preparation for admission to the BRC, any pre-admission evaluations, assessments, and training reports must be provided to the admitting BRC program prior to admission.

(2) Upon receipt of an application, the BRC reviews it to confirm the Veteran's appropriateness for admission to the BRC Program. This review determines that:

(a) The application is administratively complete.

(b) The ocular and vision data documented by a licensed eye care practitioner and provider in the ocular health examination and any low vision clinical examination is consistent with legal blindness if the Veteran is being admitted on the basis of legal blindness status.

(c) If the Veteran's eye disease(s) or vision condition(s) is stable and there are no treatment procedures pending. An exception to this may be made under the following circumstance: a direct hospital transfer for blind rehabilitation training to a BRC is permitted for a patient who is in immediate need of blind rehabilitation services in order to manage health care regimens and health literacy prior to hospital discharge. This Veteran must be medically stable and the BRC must have a bed available for admission. If a bed is not available, the Veteran awaiting transfer must be given highest priority for the next available bed.

(d) The Veteran's medical and psychological status is stable in order to maximize the Veteran's potential to benefit from the program.

(e) Upon receipt of a referral, the BRC staff reviews it to confirm the Veteran's appropriateness for admission to the BRC Program. An application is considered complete if the information listed in subparagraph 15 c(1) is provided.

(f) When additional information is needed to confirm the appropriateness of the Veteran for the program, the BRC must notify the VIST Coordinator. The VIST Coordinator must respond to the BRC with a plan of action within 10 working days, and the requested information must be received within 30 days (except for audiology issues which have a 90-day time frame), or an explanation provided as to why the information cannot be submitted within the 30-day time frame. The application is placed in the “in review” status in the national database pending receipt of information. If information is not provided in the designated time frame, the application is cancelled (considered incomplete) and returned to the VIST Coordinator.

(g) When review of an application indicates that the Veteran is not appropriate for admission, BRC administration consults with the referring VIST Coordinator before a final decision is made in order to present the rationale for the decision, and to consider any extenuating circumstances. Cancelled applications require written and verbal notification from the BRC to the Veteran, with a courtesy copy of the notification to the referring VIST Coordinator. This notification must provide the rationale for the cancellation along with a recommendation to consult the VIST Coordinator regarding alternative services.

(h) When an application is cancelled due to receipt of an incomplete application, the application is returned to the VIST Coordinator with notification sent to the National Program Consultant.

(i) Upon receiving a complete application, the BRC accepts or cancels the Veteran applicant for admission to the program within 20 workdays.

(j) Each application (referral) is added to the BRC wait list and the Veteran is informed of this decision through formal correspondence. This letter must include an estimated wait time for admission, as well as any cost that may be incurred by the Veteran in accordance with VHA policy. A courtesy copy of this letter must be forwarded to the Veteran’s VIST Coordinator. The BRC forwards the required documents to the Health Administration Service at the facility where the program is located ensuring that applicants are properly enrolled in the VA system.

(3) After a Veteran has been accepted for the rehabilitation program, the BRC must provide information regarding the scope of services and estimated duration of training to the Veteran. The BRC also provides the Veteran scheduled for admission with appropriate information concerning clothing, footwear, equipment, details of daily life at the BRC, and any pertinent local information. The Veteran and the BRC must mutually agree upon the reporting date and travel arrangements in accordance with VA policy. The referring VIST Coordinator (and BROS where applicable) will be notified of these arrangements.

(4) The BRC must cancel the application of any Veteran who declines three offers of admission to the BRC. The Veteran must be advised to reapply through the VIST Coordinator when ready to attend. Cancelled applications require notification from the BRC to the Veteran, with a courtesy copy to the referring VIST Coordinator.

(5) Whenever a BRC referral is cancelled, information will be entered by the BRC in the comments section of the database detailing the circumstances leading to the action taken on the referral. Legend for Application (Referral) Status:

<b>Database entry</b>	<b>Definition</b>
Pending	No action taken on referral
In Review	Awaiting acceptance
Accepted	The patient will receive care
Offered	First date of service offered
Scheduled	Actual care scheduled date
Admitted	Admitted to BRC for service
Discharged	Discharged from BRC
Completed	Non BRC care was completed (not for BRC use)
Transferred	Transferred from BRC to other medical unit
Cancelled	Referral was cancelled by Blind Rehabilitation
Withdrawn	Patient withdrew from service

## **15. RECRUITMENT AND PROMOTION OF VIST COORDINATOR**

a. In a health care facility where a VIST Coordinator position exists or is to be established, the position needs to be organizationally aligned under the Chief of Staff. VIST Coordinator positions are advertised at the medical center in which the position resides. Positions are Title 38 Hybrid positions and subject to a VA Blind Rehabilitation Service (BRS) Professional Standards Board (PSB) review and recommendation.

b. Although the full performance level position is at the GS-12, recruitment may be at the GS-11 level. The position may be filled non-competitively at the target grade by reassignment of eligible candidates or qualified higher-level candidates may change to the lower grade. The position may also be filled by qualified candidates eligible for excepted appointments under the Schedule A, and the 30 Percent Disabled Veteran Appointment Authorization.

c. Promotion to the target grade depends on performance and program development.

d. Each facility having a position identified as VIST Coordinator, GS-601 series "Blind Rehabilitation Specialist," must ensure that the position description and functional statement reflecting the position's organizational alignment is updated and available upon request.

e. The recruiting facility determines the grade level at which the position will be filled and forwards the name of the appropriate candidate to the BRS PSB for review. In order to promote

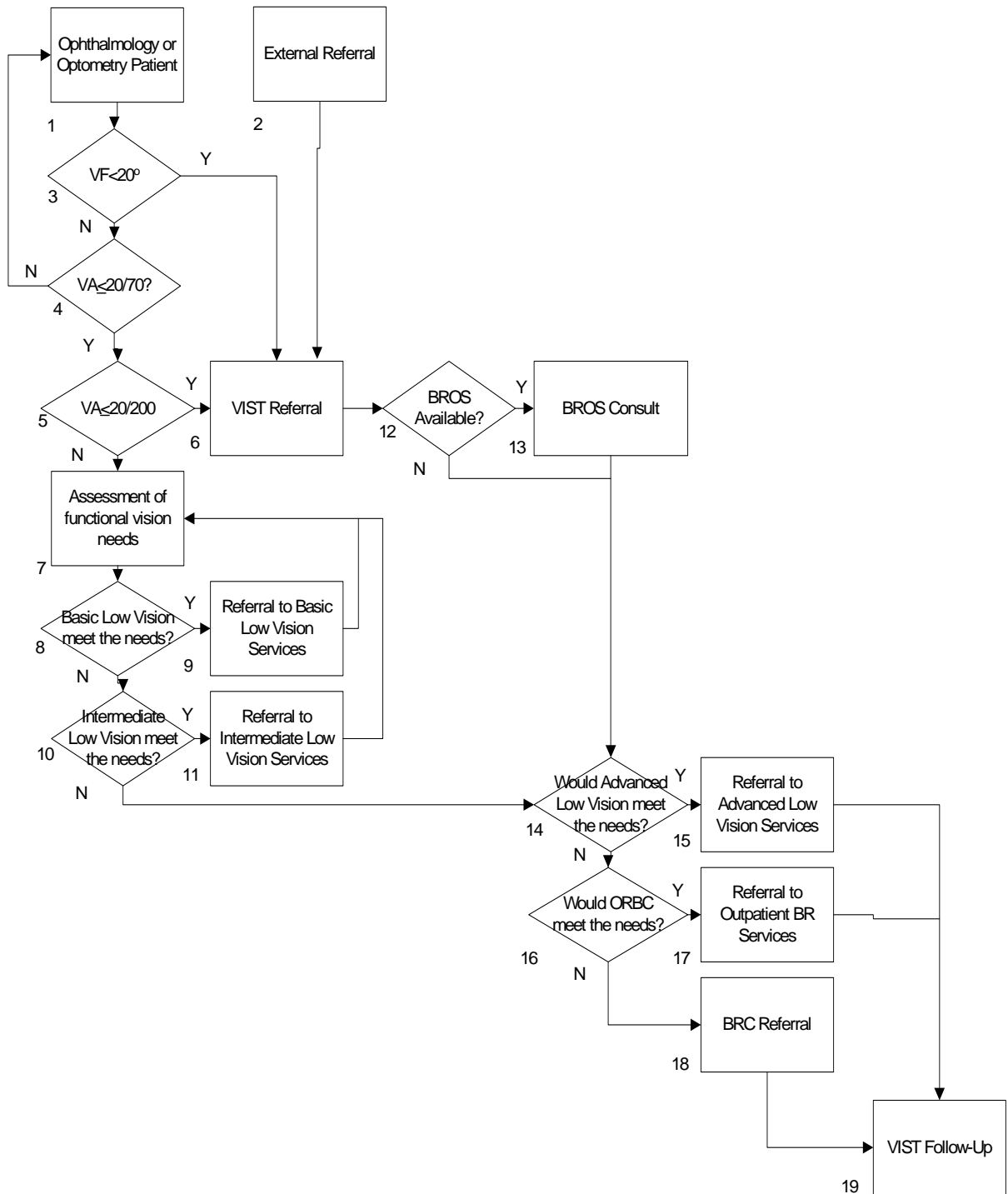
the incumbent to the full performance level, the facility must obtain the approval of the Blind Rehabilitation Service PSB.

f. Facilities are encouraged to involve a BRS NPC in the recruitment and selection of VIST Coordinators. The National Consultant is responsible for providing the blind rehabilitation-specific orientation and training.

## 16. REFERENCES

- a. Optometric Clinical Practice Guidelines, American Optometric Association (<http://www.aoa.org/x4813.xml>)
- b. Preferred Practice Patterns, American Academy of Ophthalmology. (<http://one.aao.org/CE/PracticeGuidelines/PPP.aspx>)
- c. Social Security Disabilities Programs, Medical/Professional Relations, Disability Evaluation under Social Security, Section 2.00 Special Senses and Speech, Statutory Blindness. (<http://www.ssa.gov/disability/professionals/bluebook/2.00-SpecialSensesandSpeech-Adult.htm>)
- d. VHA Handbook 1170.1, Accreditation of Veterans Health Administration Rehabilitation Programs.
- e. VHA Handbook 1173.5, Aids for the Blind.
- f. VHA Handbook 1173.2, Furnishing Prosthetic Appliances and Services.
- g. VHA Handbook 1172.1, Polytrauma Rehabilitation Procedures.
- h. VHA Handbook 1173.12, Prescription Optics and Low-Vision Devices.
- i. VHA Handbook 1121, VHA Eye Care.
- j. VHA Handbook 1110.02, Social Work Professional Practice.
- k. VHA Handbook 1010.01, Transition Assistance and Case Management of Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) Veterans.
- l. VHA Handbook 1173.14 Home Improvements and Structural Alterations (HISA) Program.

ALGORITHM FOR VISUALLY IMPAIRED VETERANS



**LEGEND:** VF-visual field VA-visual acuity VIST-visual impairment service team  
 BROS-blind rehabilitation outpatient specialist ORBC-outpatient rehabilitation blind clinic  
 BR-blind rehabilitation BRC-blind rehabilitation center

**ANNOTATIONS TO ALGORITHM FOR VISUALLY IMPAIRED VETERANS**

This algorithm, developed by the Visual Impairment Advisory Board (VIAB), shows the movement of referrals through the continuum of care for visually impaired Veterans.

1. Veterans with vision loss are identified primarily in optometry and ophthalmology eye clinics.
2. External referral means referral by sources other than optometry or ophthalmology and therefore includes primary care and other referral sources. Veterans with visual impairment may be referred to the Visual Impairment Services Team (VIST) Coordinator from providers (e.g., primary care), outside services (e.g., community or state) or by the Veterans themselves. The VIST Coordinator needs to assess these referrals and when the level of visual impairment is in question, and refer the Veteran to the eye clinic for formal assessment. If the documentation of visual impairment is adequate, referral to appropriate visual impairment services needs to be completed.
3. Visual field in legal blindness is less than 20 degrees centrally using the III4e isopter, on the Goldmann kinetic perimetry test using appropriate near correction, or IV4e isopter, if aphakic or not well adjusted to an intraocular lens implant or contact lens.
4. If a patient has better than 20/70 best corrected acuity in the better vision eye, they must exit the algorithm as they do not fit within the VIAB definition of low vision (vision loss equal to or greater than 20/70 in the better seeing eye with correction) nor the Veterans Benefits Administration (VBA) definition of legal blindness (Disability reference guide). However, patients with visual acuity better than 20/70 must continue to be followed in the eye clinic basic low vision service and if their acuity declines, must be reassessed for low vision services as defined by VIAB. If a patient does not meet the VIAB definition of low vision, this in no way limits the Veteran's access to low vision services. Measurement of visual acuity needs to be performed for disability measurement.
5. Visual acuity is best corrected resolution in the better vision eye (not using eccentric fixation or eccentric viewing) as measured by the appropriate chart. Veterans who are legally blind are referred to VIST for case management. Veterans who require case management (Veterans with legal blindness, and subsequent to the development of this algorithm, includes Veterans with excess disability and severe functional deficit that requires case management) are referred by VIST to Blind Rehabilitation Outpatient Specialist (BROS), advanced outpatient low vision services, outpatient blind rehabilitation services, inpatient blind rehabilitation services and are followed by VIST.
6. The VIST Coordinator must assess the patient using the guidance of VHA Handbook 1174.02. VIST evaluation must include, but not be limited to:
  - a. Cognitive abilities that may limit the value of training or suggest alternatives of training;
  - b. Social and economic ability to attend training; and
  - c. Functional vision needs.
7. Low vision patients must be assessed for visual functional needs in order to best match

the Veterans' functional needs with the available low vision services.

8. Basic low vision services include optical devices (e.g., spectacle magnification and some magnification devices) and environmental adaptations (lighting and contrast).

9. Basic low vision services need to be available in all eye clinics, although training in use of low vision devices is limited.

10. Intermediate low vision services provide a larger array of optical devices. In addition, there is more training in use of the low vision devices and some limited training in Activities of Daily Living (ADL).

11. Intermediate low vision services need to be provided within the VISN. When the low vision program is completed, the patients need to be reassessed annually to determine if additional needs have developed.

12. BROS are not available at all facilities. When BROS are available, the VIST Coordinator needs to consult the BROS to determine which component of the continuum of care would best meet the needs of the Veteran. *NOTE: The program that best fits the functional and social needs of the Veteran should be recommended. BROS treatment is outlined in the BROS Handbook (1174.01).*

13. Advanced low vision services provide the full spectrum of optical devices, including closed circuit TV readers (CCTV) and Electronic Optical Enhancement Devices (EOEDs). In some cases these programs are appropriate for legally blind patients.

14. Advanced low vision services need to be provided in at least one site within each VISN with hoptel or lodging arrangements.

15. Advanced outpatient blind rehabilitation (AOBR) services provide a broad spectrum of visual and social services. This program is aimed primarily at the legally-blind Veteran with some residual visual field. Some legally-blind patients who have remaining vision may be best served by an AOBR program.

16. AOBR programs need to be available within the VISN or shared with a nearby VISN. The Veteran needs to be able to access this program either while living at home or through the use of lodging or hoptel beds. Services may be provided by a Department of Veterans Affairs (VA) program, contract care, or by a combination of community and VA services.

17. Blind Rehabilitation Centers (BRC) offer the full spectrum of visual, social, and medical services. Legally-blind Veterans who have limited vision, and those with medical co-morbidities are best managed in a BRC.

18. Patients who require advanced low vision clinics, outpatient BRCs, as well as those attending inpatient BRCs may be on VIST caseloads due to either legal blindness or an excess disability are offered lifetime case management.