Editor's perspective

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Overcoming barriers to low vision care

Depending on which statistics are consulted, the estimated number of visually impaired and blind over the age of 40 years in the United States is somewhere between 1.5 million and 13.5 million. It is important to note that these numbers do not include individuals under the age of 40 years, individuals with visual-field loss (either by the Social Security Administration's definition of legal blindness due to visual-field loss, or partial or sector visual-field loss), those who experienced debilitating photophobia, or those with "normal" acuity but metamorphopsia. And, as at least one model projects, these numbers pale by comparison to the estimated 38 million bilaterally blind (visual acuity worse than 20/400) worldwide.

On March 21, 2002, at the Vision Problems in the United States Symposium, sponsored by Prevent Blindness America and held in our nation's capital, new statistics were released on the prevalence in the United States of cataracts, macular degeneration, diabetic retinopathy, glaucoma, and blindness and visual impairment. Under a grant from Prevent Blindness America to Johns Hopkins University, investigators determined that more than 3.4 million Americans ages 40 and older are blind or visually impaired. This number is based on "blindness" being defined as 20/200 or worse in the better-corrected eye, or visuals fields of less than 20 degrees in diameter in the better-corrected eye, and "visual impairment" as people with 20/40 or worse in the better eye, even with eyeglasses. In defining this problem, however, the question still remains, "Where do blind and visually impaired patients go after they have been told nothing more can be done (with conventional glasses, contact lenses, medically or surgically)?"

One of the presenters at this meeting (the sole presenting optometrist) discussed some of the barriers to low vision care (as identified by the National Eye Institute) and some ways these issues are being addressed. All those involved in the field of vision rehabilitation—and, for that matter, all of us who have a moral and ethical responsibility to our patients and (ultimately) the public—can begin to think about how these barriers might be overcome. In her presentation, Dr. Kathleen F. Freeman, chair of the AOA Low Vision Section, addressed the issues of *lack of awareness of services*, *lack of access to information*, *noncoverage of vision rehabilitation services and devices by third-party payers*, and *lack of providers*.

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The National Eye Institute's National Eye Health Education Program (NEHEP) is attempting to address the first two areas of *lack of awareness of services* and *lack of access to information*. This program targets visually impaired people ages 65 and older, as well as younger people who are at risk (such as Hispanics and African Americans) for visual impairment from diabetic eye disease and glaucoma. The goal of the Low Vision Education Program is to make visually impaired people, their family and friends, and caregivers aware of low vision rehabilitation services. It includes educational material for lay people, as well as health professionals (including eye doctors). Another recent example of an awareness campaign, sponsored by Novartis, is the release of actress Lauren Bacall's comments about macular degeneration. The announcement is targeted at increasing the public's awareness of the nature of age-related macular degeneration, its potential consequences, and the need for seeing an eye doctor regularly. This message is

a great start, but falls short of explaining that there is assistance for those who, in fact, suffer the ravages from this (and other) visually debilitating condition(s). The success of these types of programs will rely on active participation on the part of eye doctors, other vision rehabilitation professionals (i.e., orientation and mobility instructors, occupational therapists, teachers of the visually impaired, social workers, etc.), and industry involved in supporting the habilitation and rehabilitation of these patients (i.e., drug industry, product industry, etc.).

The issue of *lack of coverage* is being addressed in some states by Local Medical Review Policies (LMRPs) on Vision Rehabilitation, which have been adopted by Medicare carriers and allow some rehabilitation codes to be used with visual impairment codes. Under these LMRPs, and in accordance with strict guidelines, some vision rehabilitation services provided in the office can be billed. Another approach to obtaining Medicare coverage for vision rehabilitation services has been the Medicare Vision Rehabilitation Services Act of 2001, which has now been presented to both the U.S. House and Senate. It seeks to expand Medicare coverage for low vision rehabilitation services not only in the office, but—when appropriate—in the patient's home. (As an aside, both the AOA Low Vision Section and the Washington AOA staff are to be commended for their tireless efforts to make sure the language in this bill was beneficial to visually impaired senior citizens.) Finally, the AOA Low Vision Section continues to encourage more optometrists and optometry students to provide these very needed services, taking on the issue of *lack of providers*.

We should be very proud of our representation at this most-important symposium and the message that was presented. It is up to all of us to not "drop the ball" and carry this message forward.

The care of the visually impaired patient, as well as the care of the population at large, depends on identifying best practice modes and being able to support that care through documentation. The public and third-party payers justifiably demand this. In 1993, the American Optometric Association formed a Commission on Quality Assessment and Improvement, the results of their efforts are provided in this issue of *Optometry*. The information found in this article ("Quality Assessment and Improvement in Optometric Practices") should serve as an excellent platform from which to develop practices that will meet and exceed the demands placed on the practices of optometry.