The Southeast Ontario Vision Rehabilitation Service

SOVRS

Kingston Health Sciences Centre

Centre des sciences de la santé de Kingston

Hôpital Hotel Dieu Hospital

KGH Hôpital Général de Kingston General Hospital

VISION LOSS REHABILITATION ONTARIO

RÉADAPTATION EN DÉFICIENCE VISUELLE ONTARIO

Objectives

- What is Low Vision?
- Challenges and gaps
- Prevalence
- Southeast Ontario Vision Rehabilitation Service
- SOVRS services
- Opportunities for collaboration

Key Concepts

Low Vision (and blindness):

Visual impairment* that **cannot be corrected** by medical or surgical treatment or by standard eyeglasses.

and

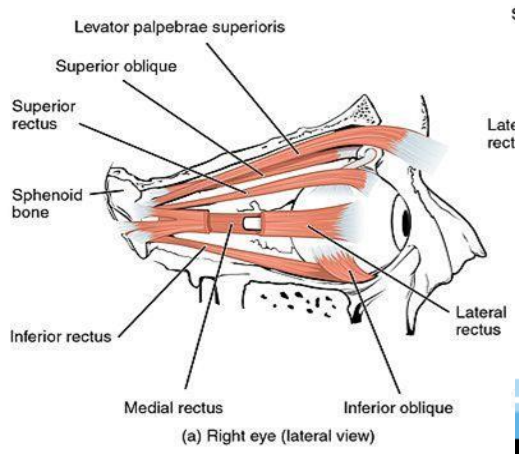
Impacts a person's **safety, independence and ability to function**.

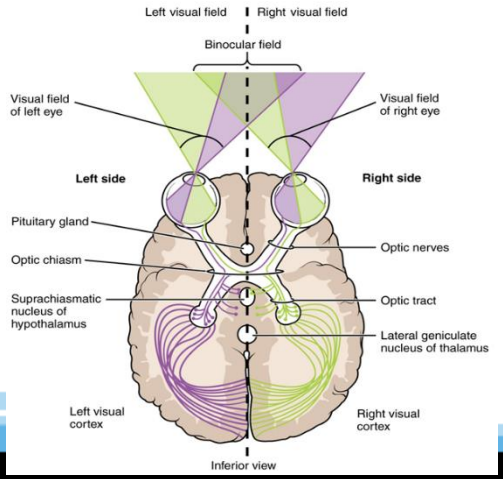
How common is low vision/blindness?

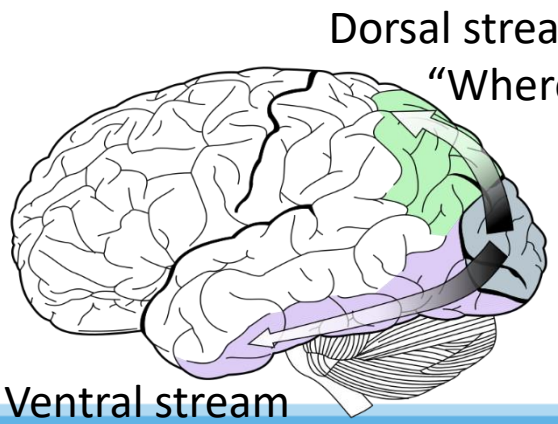
- 1 in 20 of Canadians
- Increases with age (1 in 6 Canadians age 75-84 years old)
- 85% of Canadians with seeing disability had 2 or more co-morbid conditions (Canadian Survey on Disability)

Stroke can affect:

1. function of the eye (e.g., pupil constriction, extraocular muscles)
2. Visual pathways from the eye to the brain
3. Visual processing areas of the brain







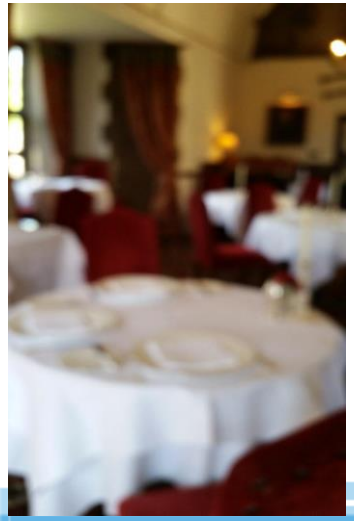
Post-Stroke

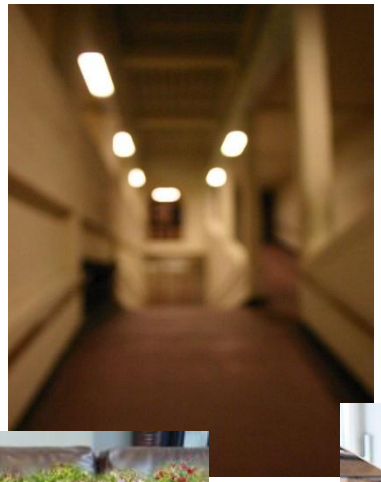
- Estimated prevalence of visual impairment early after stroke of 65%
- A significant proportion of stroke patients have visual impairments that are not recognized or addressed during recovery.
- Most functional activities are visually dominant
  - Visual deficits can significantly impact independence and function
  - They can lead to deficits in non-visual areas such as memory, cognition and motor control

Visual function impacts safety, independence, participation











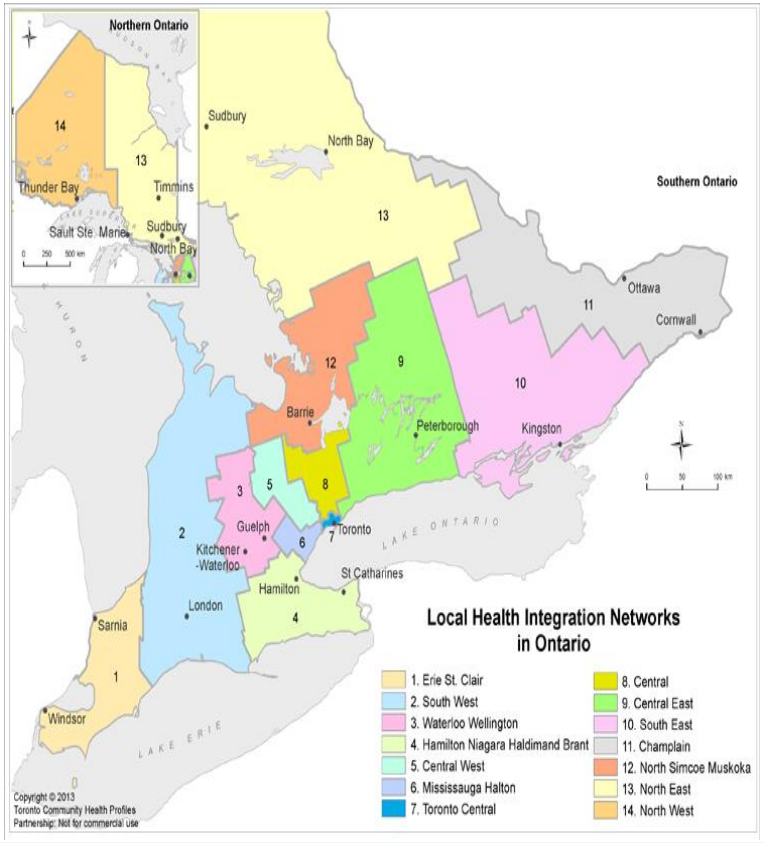
Integrating vision loss rehab

Integrating vision rehabilitation into stroke rehabilitation is consistent with Canadian stroke Best Practice

- Discharge planning from inpatient care should consider any significant changes to function and identify any barriers to integration into the community including safety, equipment, and modifications.
- transition planning should include caregiver training, and access to resources to increase the patient's independence

Systemic gaps

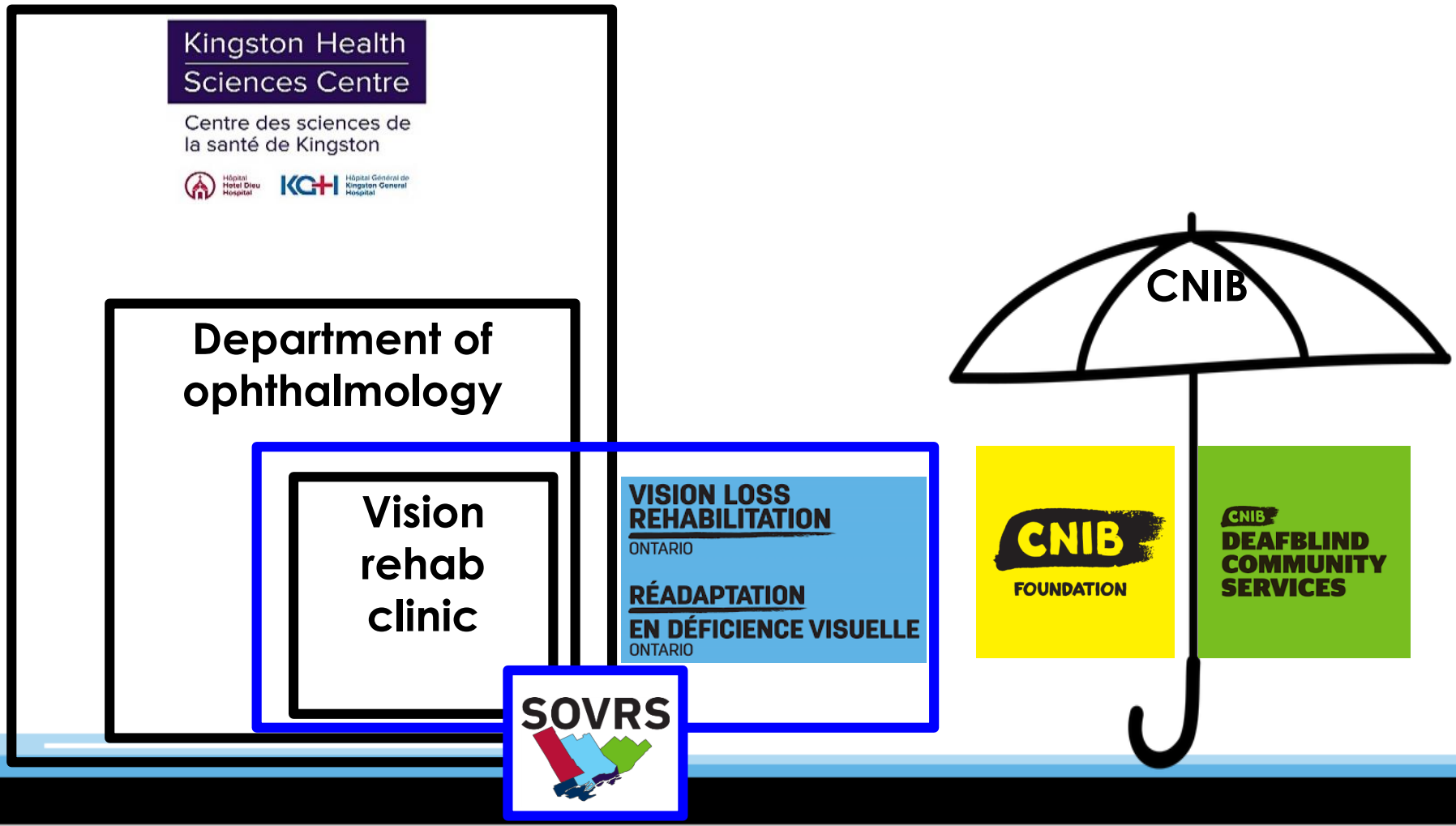
- Gaps in Vision Rehabilitation Service Delivery:
  - Integration
  - Transitions
  - Providers
  - Awareness
  - Access
  - Wait Times



Southeast Ontario Vision Rehabilitation Service (SOVRS)

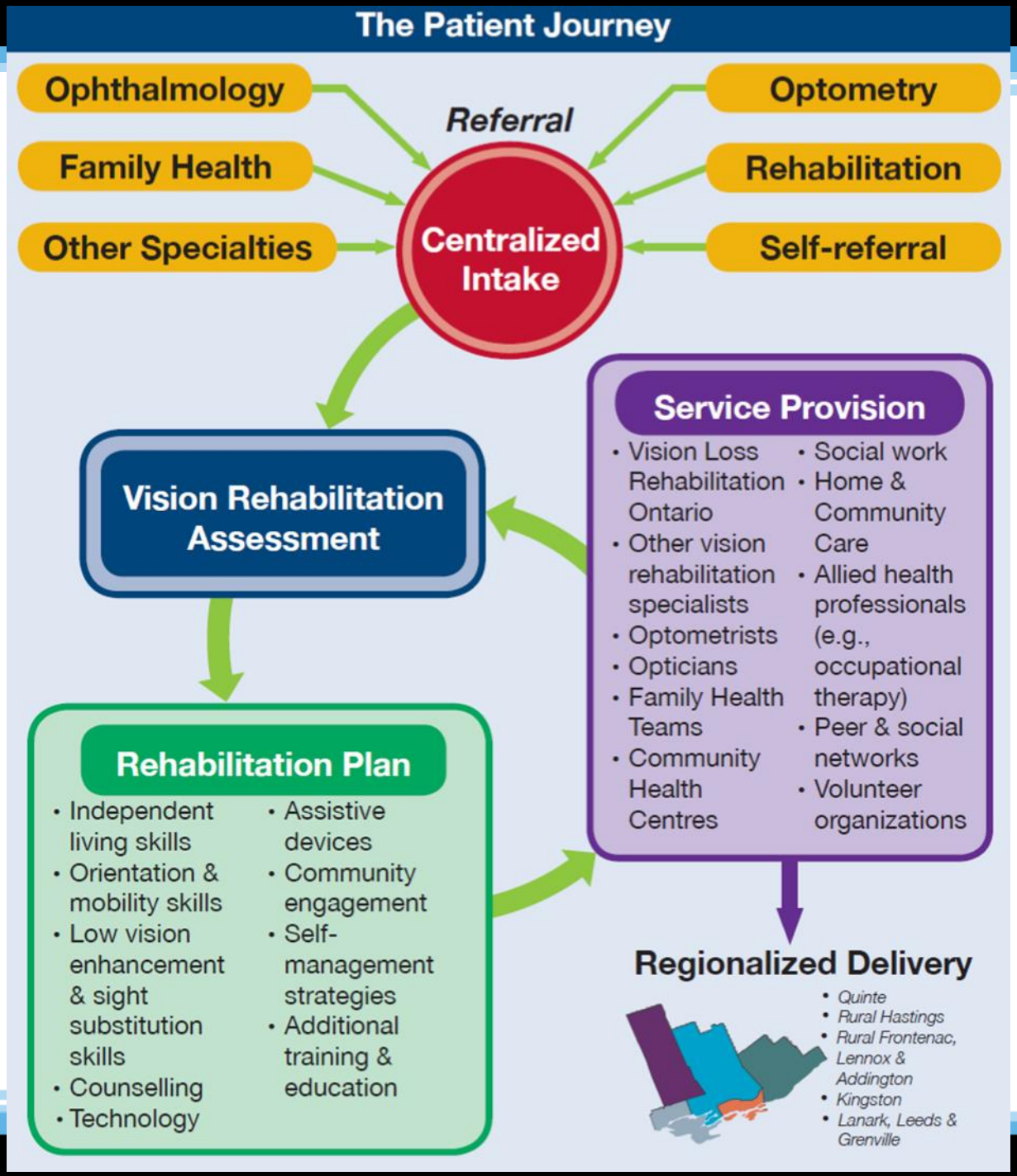
Person-centred, integrated system of care for individuals with vision loss

SOVRS within the system



What does SOVRS provide?

- Vision Rehabilitation
  - Comprehensive Vision Assessments
  - Individualized Rehabilitation Plans
  - Rehabilitation Therapy
- Centralized Intake
- System Navigation
- Interprofessional Team and Coordinated Service Provision
- Partnerships and Collaboration


The Patient Journey
Ophthalmology
Family Health
Other Specialties
Referral
Centralized Intake
Optometry
Rehabilitation
Self-referral
Vision Rehabilitation Assessment
Service Provision
• Vision Loss Rehabilitation Ontario
• Other vision rehabilitation specialists
• Optometrists
• Opticians
• Family Health Teams
• Community Health Centres
• Social work
• Home & Community Care
• Allied health professionals (e.g., occupational therapy)
• Peer & social networks
• Volunteer organizations
Rehabilitation Plan
• Independent living skills
• Orientation & mobility skills
• Low vision enhancement & sight substitution skills
• Counselling
• Technology
• Assistive devices
• Community engagement
• Self-management strategies
• Additional training & education
Regionalized Delivery
• Quinte
• Rural Hastings
• Rural Frontenac, Lennox & Addington
• Kingston
• Lanark, Leeds & Grenville

Where does SOVRS fit in?

Inpatient rehab → Discharge planning → Homecare

Step 1:Identify visual issues (screen)

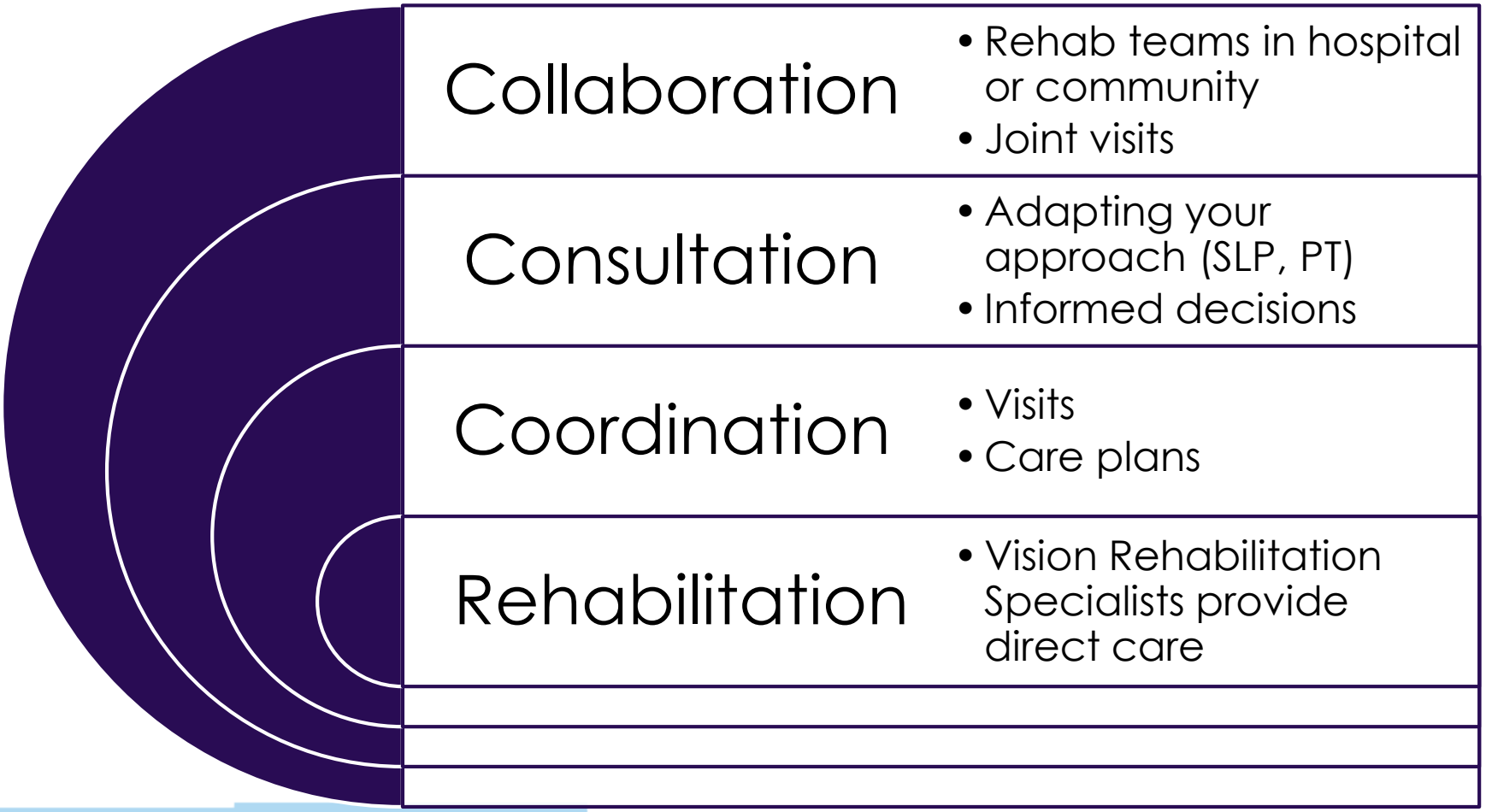
Step 2: Refer to SOVRS (and neuro-ophthalmology)

Step 3: SOVRS Intake (Share info / discuss rehab plan)

Step 4: Work together to rehabilitate
-Consult / collaborate/ coordinate

Outpatient rehab → Late stage recovery → Return to work or school

How can we work together?



Low Vision Skills

- **Reading** (e.g., meds, labels, digital displays, SLP handouts)
- **Writing** (e.g., appointment calendar, notetaking and other cognitive strategies)
- **Seeing details** (e.g., fine motor activities)
- **Lighting and environmental** assessments
- **Application of strategies in everyday life**

Independence / Daily Living

- **Self-care** (e.g., labeling meds, searching closet)
- **IADLS** (e.g., cooking, groceries, ID money)
- **Safety and independence** in other daily activities (e.g., Tech use, audiobooks, leisure)

Orientation and Mobility

- **Community mobility** (e.g., getting to appointments, work, sighted guide training, augmentations to mobility aid use)
- **Preventing falls/injuries** at home and in the community

Technology access

- **Built in** accessibility features
- **Computer** access for home, work, school, etc.
- **High tech** reading and writing aids

Case Example

- 46 year old woman with ischemic stroke affecting primarily vision in November 2021
- Significant change to acuity, contrast sensitivity, field loss and colour perception
- Client unable to work, complete ADL/IADL, mobility outside home.
- Rehabilitation team did not consult or refer client until 3 months later at insistence from spouse

Case Example

- 50 year old woman with hemorrhagic stroke resulting in hemiparesis, visual field loss, contrast sensitivity and visual fatigue in 2018
- Participated in rehabilitation for more than a year
- Client unable to read, tolerate light, using a computer (screen too bright) etc.
- Self-referred to SOVRS
- 6 months later they read a speech via zoom to a large audience.

Complex challenges → collaboration!

- What do you do now with clients who have blindness or low vision?
- Where can you see room for collaboration?

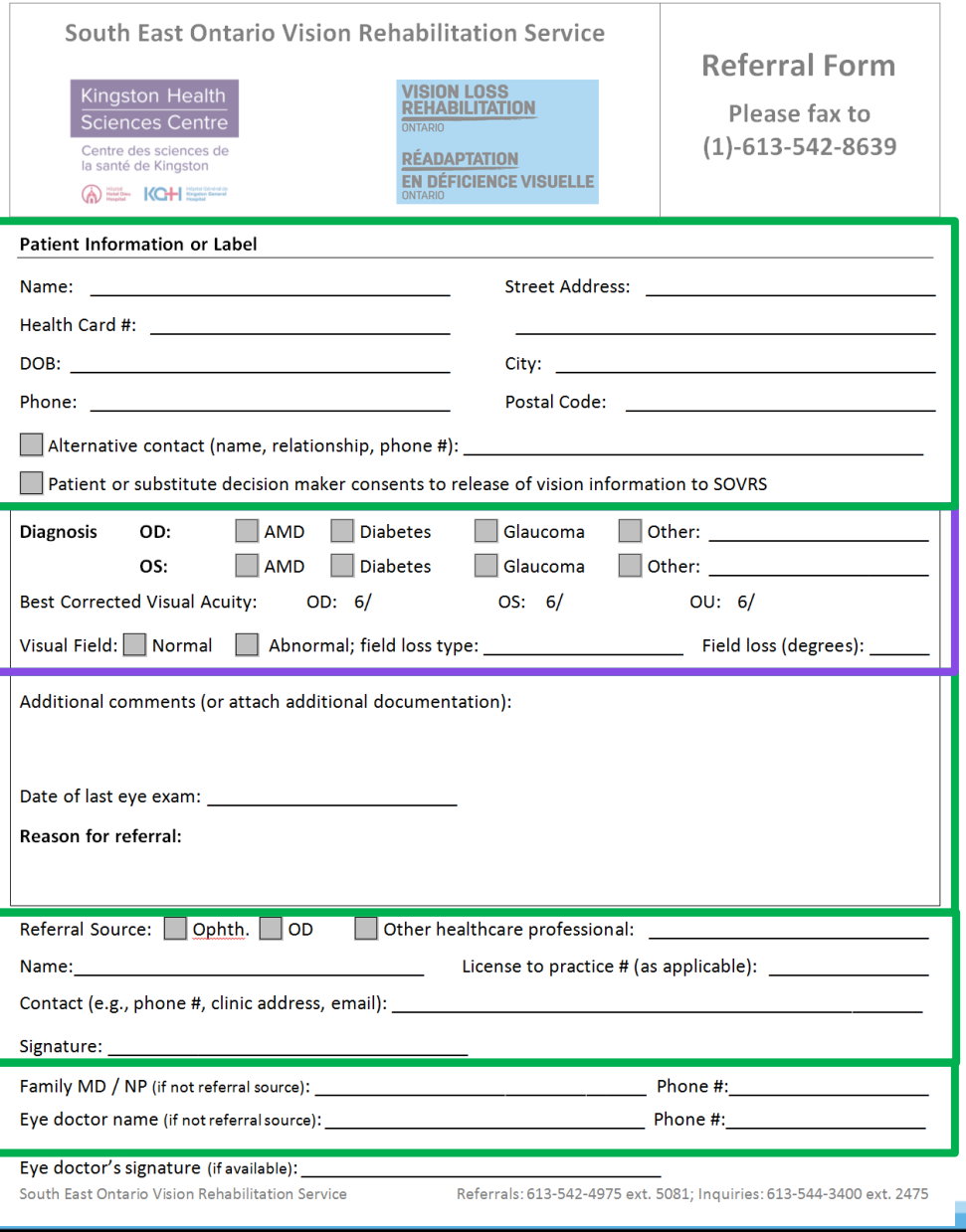
Please add:

Client/patient info (patient label okay)

Relevant details (e.g., DMII, BKA + referral reason (e.g. small print, falls, etc.)

Your info

Name / info to ID eye doc (e.g., "Galen")



South East Ontario Vision Rehabilitation Service

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VISION LOSS REHABILITATION ONTARIO
RÉADAPTATION EN DÉFICIENCE VISUELLE ONTARIO

Referral Form

Please fax to (1)-613-542-8639

Patient Information or Label

Name: _____ Street Address: _____

Health Card #: _____ _____

DOB: _____ City: _____

Phone: _____ Postal Code: _____

☐ Alternative contact (name, relationship, phone #): _____

☐ Patient or substitute decision maker consents to release of vision information to SOVRS

Diagnosis OD: ☐ AMD ☐ Diabetes ☐ Glaucoma ☐ Other: _____

OS: ☐ AMD ☐ Diabetes ☐ Glaucoma ☐ Other: _____

Best Corrected Visual Acuity: OD: 6/ OS: 6/ OU: 6/

Visual Field: ☐ Normal ☐ Abnormal; field loss type: _____ Field loss (degrees): _____

Additional comments (or attach additional documentation):

Date of last eye exam: _____

Reason for referral:

Referral Source: ☐ Ophth. ☐ OD ☐ Other healthcare professional: _____

Name: _____ License to practice # (as applicable): _____

Contact (e.g., phone #, clinic address, email): _____

Signature: _____

Family MD / NP (if not referral source): _____ Phone #: _____

Eye doctor name (if not referral source): _____ Phone #: _____

Eye doctor's signature (if available): _____

South East Ontario Vision Rehabilitation Service Referrals: 613-542-4975 ext. 5081; Inquiries: 613-544-3400 ext. 2475

Bonus info

Details on vision/ attach any reports available

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- Heart and Stroke Foundation of Canada, Stroke Best Practices, May 2018, referenced from website on March 9, 2021 from, https://www.strokebestpractices.ca/recommendations/stroke-rehabilitation/delivery-of-inpatient-stroke-rehabilitation

The challenge facing the healthcare system

- **Prevalence**: 1 in 20 (1 in 6 of 75-84 yr olds) – will double in 20 years
- **Vulnerable** sub-population
  - **Isolated** (45% of SELHIN rural)
  - **High risk population**:
    2x risk of falls, 4x risk of hip fractures
    3x risk of depression
    3 years earlier in long-term care facilities
  - Multiple **co-morbidities** (85% people with low vision have 2 or more other disabilities)

(Alijied et al. 2018; Stats Can. 2019; Rumaisa, Aubin, Buhrmann, Sabeti, & Freeman, 2018; Klein, et al., 1998; McCarty, Fu, &