

South Texas Risk Management Model
Decision making based on clinical indicators

4. Intervene in the home setting where potentially devastating events such as falls are likely to happen.

The VIST Program in south Texas has developed a model to meet these needs. We have established a model that is an evolution in service provision. The VIST program has seen the need to move from a strictly hospital based model of services that focuses on the institutional setting for providing the services to a model with a focus on the individual in their home setting. We refer to this model as Risk Management. In such a system hospital based training is an option, but not the sum and substance of all of the available services offered. Our goal for services includes:

1. Intervention in a timely fashion in the least restrictive environment
2. Reduction of negative outcomes for our patients
3. Reduction of fall risk through modification of the home environment
4. Reduction of cost for our medical center and by increasing the ability of our patients to stay on their treatment regimes
5. Most effective and efficient use of VA and other agency resources

Who Qualifies as Low Vision under the model?

Legal blindness is easy to define, there is a standard measurement that applies everywhere in the United States:

- No better than 20/200 acuity OU with best correction (as defined on a Snellen Eye Chart) or
- Visual field no larger than 20 degrees in both eyes

Under the risk management model we also deal with functional vision loss. The following is a definition of functional vision impairment of functional visual impairment*:

Functional visual impairment is a significant limitation of visual capability resolution from disease, trauma or congenital condition, which cannot be fully ameliorated by standard refractive correction,

South Texas Risk Management Model
Decision making based on clinical indicators

medication or surgery, and is manifested by one or more of the following:

1. Insufficient visual resolution (worse than 20/60 in the better eye with best correction of ametropia)
2. Inadequate field of vision (worse than 20 degrees along the widest meridian in the eye with the more intact central field) or homonymous hemianopia
3. Reduced peak contrast sensitivity (greater than 1.7 log CS {contrast sensitivity} binocularly) AND
4. Insufficient visual resolution or peak contrast sensitivity (see 1 and 3) at high or low luminances within a range typically encountered in every day life.

*Source: Lighthouse International

By early intervention in the risk management model the concept of prevention of negative outcomes is introduced. The benefit of this concept is that the individual veteran is prevented from "bottoming out" physically and psychologically if identified early and intervention is begun in a timely fashion.

Typical examples of functionally blind cases would be those veterans identified by their primary care provider as being unable to read medication bottle labels or be able to correctly load insulin syringes due to impaired vision. In these cases timely intervention can be a matter of life or death.

The best example of the value of early intervention is the prevention of further sight loss. A veteran with the right tools is able to follow his/her treatment regime, avoids further medical complications, and maintains their present level of vision.

How is Risk Defined?

First, we have the immediate type of risk. A veteran cannot read his or her medications and cannot take them accurately is at risk. This is a clear risk with possible immediate and dire consequences. There is a clear need to intervene immediately in these type cases.

South Texas Risk Management Model Decision making based on clinical indicators

An important point to make here is the uniqueness of each veteran's situation. If a veteran lives in a facility where his medications are managed for him, or if a family member controls medications, then the risk factor may be mitigated and we would not have the urgency to intervene. In the risk management model, it is important that the VIST Coordinator and BROS aggressively screen veterans, see them in their home settings, and have a vigilant mindset to identify potential risk factors.

Next, we have "accidents waiting to happen" types of risk. We really do not know when or where, but we know if these patients go long enough they will have something negative happen that is harmful to them. It could be a fall over an unseen obstacle, a burn while cooking or some other negative outcome.

These individuals may be potential candidates for hospital based blind rehabilitation center treatment. At this type of facility, the veteran receives a broad-based program that is supposed to take into account their home circumstances and tailor a program to their needs. The downside to this is the residential nature of the program. Many of our veterans cannot or will not attend a residential program for a wide range of reasons.

Mixed in with this is another type of Risk where a person makes poor adjustment to sight loss. They do not eat as well as they did in the past, they do not get as much exercise, and in general the condition of their life diminishes. In the long term this has a negative effect on their overall health status.

Finally, we have the issue of social isolation. While this may not seem to be an immediate risk, it does severely impact the quality of life and the overall health and psychological status. The undesired consequence could be undiagnosed and untreated clinical depression.

Intervention Models

There is no one size fits all model for intervention. Intervention is broad spectrum with a number of treatment options. These include:

VIST Coordinator – Often the first point of contact, the VIST Coordinator is attuned to assessing the needs of the veteran. The Coordinator also serves as the triage point of low vision referrals. As the triage point the VIST Coordinator must explore short term and long-term intervention options to meet the Risk requirements. This

South Texas Risk Management Model
Decision making based on clinical indicators

may entail an immediate scheduling of a low vision exam and the long-term referral to a BRC.

Blind Rehabilitation Outpatient Specialist (BROS) – BROS serves as the eyes and ears of the Visual Impairment program in the field. BROS can also provide the first line of intervention for the veteran. The ability to go to remote areas and see veterans in their home setting cannot be replaced. First line intervention can be conducted in conjunction to or referrals to other agencies and disciplines. A typical referral would be for a Low Vision Exam. This idea of an in the field agent is most valuable in the assessment of the structural environment and modifications needed to reduce the risk of falls and other potential injuries.

Local Low Vision Exams - Low vision exams provide the way to get the most appropriate low vision and optical devices to the individual veterans as quickly as possible. Having a low vision clinic is a core part of the risk management model in south Texas.

The VA Eye Clinic – The Eye Clinic serves a two-fold purpose. It addresses long term eye care needs. The hope is to stabilize eye conditions, or to reverse sight loss if possible.

Local Training – In the risk management model there is a need to utilize all of the state and local services available. We do not consider these replacements for a full residential program but we do not trivialize the valuable services they can offer.

Local Newsletters – A VIST Newsletter serves as an information and teaching tool. This is intended to help break the chain of social isolation and encourages veterans to seek rehabilitation services in the VA and the community. The veteran must have a way of independently reading this information.

Phone Network – VIST employs a volunteer network of phone callers. This network has many useful purposes. We can arrange for identified veterans to be called on a periodic basis. This can prove an effective weapon against social isolation and depression. We also target the entire VIST caseload for periodic calls. This is used to pass and gather information from veterans. Often veterans have significant problems that put them at some form of Risk, but they neglect to let these problems be known. A phone network is an important link in identification of intervention needs.

South Texas Risk Management Model
Decision making based on clinical indicators

On-Line Services - On-line services are a logical extension of outreach and is this incorporated. About half of the active applications for Blind Rehab Training are computer related. The idea of some type of distance update training only makes sense in this environment. Though it targets only a select group of veterans it is a timely cost efficient way of continuing support and education.

Blind Rehabilitation Center (BRC) training - In the STVHCS We think that the hospital based training may play an important long-term role in Risk Management. However, it is not a viable option for every veteran.

Blinded Veterans Association (BVA) - The BVA helps man the VIST Coordinator office. The BVA volunteers make phone calls to veterans. The BVA participates as a stakeholder at various levels throughout the VISN in a guidance capacity. The BVA assists with surveys of their members to alert us of stakeholder needs and concerns.

Social Work Service - Social Work Service through home and clinic visits serves as both a screening point to detect veterans with vision problems and often, especially through home visits acts as an extender of the VIST/BROS outreach into the community. This is most often done when consults are made to SWS to do a home visit to a VIST patient.

Occupational Therapy (OT) - OT serves as a valuable service provider in the risk management model. Many of our veterans have multiple disabilities. This is to be expected with an aging elderly population. True addressing of a broad spectrum of problems requires a multiple disciplinary approach.

Ancillary Services - There is a need with some veterans for Diabetic Education, Podiatry, Physical Therapy, Dietetics, and many other services. Each veteran is assessed individually and connected with the needed services.

Overview

The VIS Team in South Texas consists of a VIST Coordinator, a Blind Rehabilitation Outpatient Specialist, and the resources of a Department of Veterans Affairs South Texas Healthcare System. We also collaborate with state and community services.

South Texas Risk Management Model
Decision making based on clinical indicators

Our area covers over 100,000 square miles. We look for some unique solutions to cover our large area. Our enrollment of legally blind veterans is relatively constant in the 650+ legally blind veteran range. They are spread out in a number of urban areas such as San Antonio, the Rio Grande Valley, Corpus Christi, Laredo, the Hill Country, and Del Rio. We have a number of veterans in extremely rural locations.

We use a relatively standard Clinical Pathway with all of our newly referred veterans. They will first go through a Stabilization Phase. We consider this part of a larger risk management concept in the continuum of services of care. During this Stabilization Phase timeliness is essential. A major portion of the emphasis in this phase is on safety and restoring lost visual functioning.

In this crucial time we first look to reduce potential negative outcomes. A heavy component of this portion of the program is a low vision exam performed by a qualified eye care professional and maximization of residual vision. We do this for everyone possible. Effective use of residual vision results in regaining of function and control in one's life. Restoration of function helps reduce stressors and prevents further regression due to feelings of helplessness and hopelessness.

When we have veterans with no usable vision. we look to alternative solutions in these cases. A veteran may not read medications visually, but might still be able to take medications independently. Mail might be read with an Optical Character Reader (OCR). The veteran may learn to dial the phone tactually. The examples could go on.

We continue to emphasize risk management throughout the continuum of VIST services to veterans. Risk is an element of concern that involves newly identified VIST veterans as well as established cases. A key challenge throughout the remainder of the veteran's life will continue to be successful utilization of residual vision for functional every day tasks. For non-visual veterans there is an ongoing search for better strategies and devices to restore and maintain functional ability and independence.

During the course of VIST involvement, a veteran could attend a blind rehabilitation center. Based on the clinical indicators, they may return to a BRC if circumstance or needs change. Most veterans never attend hospital based inpatient training, but all veterans require and receive local based services; this will be discussed later in this document.

South Texas Risk Management Model
Decision making based on clinical indicators

South Texas veterans lose eyesight for many reasons. The major diseases causing new VIST cases loss include diabetic retinopathy, age related macular degeneration (AMD), and glaucoma.

South Texas is a winter haven and we have our share of transplanted veterans from the northern tier. This equates to a high rate of AMD. AMD is a relatively late onset disease. Most of our veterans in this category respond very well to low vision devices. They retain a great deal of usable vision throughout their remainder of their lives.

Our blinded veterans demographics skew heavily toward veterans with diabetic retinopathy than perhaps the northern area of the country. Our cases with diabetic retinopathy are representative of not just geriatric end stage results of diabetes. Much of the growth in this area is linked to our veterans with Agent Orange exposure. Many have very serious co-morbidities. Renal disease is a major concern. A survey of our Agent Orange Veterans age 50 to 70 was completed in 2002. Of the 58 veterans surveyed 18 had major renal complications. Of those 18 seven were on dialysis. We see this as a significant trend in south Texas.

Sources of Referrals to the VIST Program

The VIST program receives new referrals from a number of sources. These include:

Within the VA:

The VA Eye Clinic: The VIST Office is located adjacent to the main Eye Clinic in our healthcare system.

Home Based Primary Care Nurses: These nurse work out of our major medical centers and refer their veterans who have severe vision disorders.

Internal Medicine Clinic and other Primary Care Clinics: We have done a great deal of education with these practioners and they do consults for the VIST program.

Urgent Care Clinic: We receive referrals directly from Urgent Care when severe vision problems are noted.

Nursing Services: Nurses in their evaluation of patients often refer when they not veterans with substantial visual loss.

South Texas Risk Management Model
Decision making based on clinical indicators

Social Work Service: Social Workers serve as an extender in the field for the VIST program. They are a prime source of referrals

Outside the VA

Local Ophthalmologists throughout South Texas: We have made significant inroads through our networking and education, and through activities with other agencies and boards of agencies serving the vision impaired. An example of this is that the VIST and BROS are board members of the San Antonio Low Vision Club and the San Antonio Low Vision Task Force.

Local Low Vision Clinic in South Texas: We receive referrals from the two major military Low Vision Clinics – the University of Texas Health Science Center at San Antonio's Low Vision Clinic and Santa Rosa Low Vision Clinic.

Texas Commission for the Blind: We have had referrals to the VA and have worked jointly on individual veteran cases.

Various Low Vision Clubs: We send our newsletter and keep in close contact with all of the Low Vision Clubs in South Texas our.

Lighthouse Seniors Program: This is a non-profit program that serves elderly blind individuals in Bexar County (San Antonio). VIST and BROS serve on the board.

Retirement Centers: Many referrals come from this avenue. Veteran services are mentioned in community health fairs and other activities that target seniors.

Word of mouth: We offer a very usable product and people respond to this.

It needs to be noted that these referrals are generated because we have a reputation for problem solving in a timely manner. We are known for providing immediate intervention. Every veteran referred to us has problems related to the functional inability to perform activities of daily living due to impaired vision.

South Texas Risk Management Model
Decision making based on clinical indicators

Stabilization Phase (0 – 6 months from referral)

It is during this phase that very critical functional skills are targeted. We want to ensure that the veteran can:

- Read
- Safely manage medications
- Eat
- Travel to appointments
- Display survival skills in the kitchen and bath
- Veteran has been given a reason for hope

Additionally we want the veteran to understand that he/she has access to the tools he or she needs to succeed. We also want the family to understand the dynamics of sight loss and their role in the rehabilitation process.

To accomplish these goals we may need to use part or all of the following:

- Low Vision Exam
- Health Needs Addressed (services provided as needed through internal VA referrals)
 - Diabetes Education
 - Podiatry
 - Primary Care Clinic
 - Women's Health Clinic
 - Occupational Therapy
 - Rehabilitation Medicine
 - Home visit by a clinical social worker
 - Counseling-education
- Medications Management (addressed through Low Vision Aids or other non-visual solutions)
- Reading Mail (addressed through Low Vision Aids or other solutions)
- Meals on Wheels, Shopping Services (if needed)
- ADA or other Travel Services (For medical appointments and shopping)
- Social Work for assistance with placement or housing and other needs
- VA Regional Office for assistance with VA Service Connection and Pension Claims (if appropriate)

South Texas Risk Management Model
Decision making based on clinical indicators

- HISA Program to effect structural safety modifications to the home setting
- Care Providers, Family, and Spouse support, education and counseling.

Notes: STVHCS was the first health chain in the VA to issue the Scrip Talk device. This system is used with individuals who cannot use residual vision to see their medications and cannot use other non-visual systems. ScripTalk is a small portable scanner that reads "smart" labels (labels with imbedded programmed computer chips) and provides speech output about the contents of a medication bottle and directions. We were also one of the first VA systems to use the Insulin Pen.

Community Integration Phase (starts during Stabilization phase)

When we start the Stabilization Phase we must already be looking at a seamless entry into community integration. Community integration is necessary on many levels. The veteran may need to have access to the community to do activities such as attend medical appointments, shop, etc. Also, access to the community may help support psychosocial needs.

- ADA (and other) travel services
- Talking Book Program
- Hadley School (correspondence school for the Blind)
- Local Low Vision Clubs in South Texas (there are numerous)
- Nutrition Centers and other Community Centers or Classes
- Service Organizations (Blinded Veterans Association and others)
- Local Co-Operatives, Co-Ops, (provide services for elderly and disabled)
- Radio Reading Service
- Voter Registration

Local Services

- BROS (normally does follow up after Low Vision Exam and provides first line intervention in the veteran's home)
- Texas Commission for the Blind
- Local non profit agencies (such as San Antonio Lighthouse for the Blind)
- Occupational Therapist (we have had veterans use under approved third party reimbursement outside of the VA)

South Texas Risk Management Model
Decision making based on clinical indicators

- Rehab Hospital (Warm Springs in San Antonio does computer training)
- ViaTrans (Para-transit)
- Co-Ops

Mid-Term Management (3 – 12 months)

- VIST serves as the triage point for vision related issues and benefits concerns. The veteran's primary care provider is the medical manager.
- Local services are continuous based on a veterans needs
- BRC training is appropriate for some of our veterans
- VIST assistance with navigating health care needs
- VIST assistance with things such as VA benefits as claims are adjudicated
- VIST newsletter is used for information and contact. The use of a newsletter is a core part of the risk management model.

During this phase and in fact during all the phases, the VIST Coordinator and BROS are monitoring the veteran's progress and adjustment. Clinical indicators are used to not only monitor but to guide the decision making process.

Long-Term Management (One year – the remainder of the veteran's life)

Again, the transition from mid-term to long-term is meant to be a seamless process. The veteran should be experiencing a well-planned, responsive continuum of care.

- VIST offers yearly reviews. Heavy emphasis is placed on safety and risk reduction.
- VIST continue to serve as triage point for vision-related and benefits concerns.
- The veterans' primary care provider is medical manager.
- Local services may continue or be instituted as new needs arise. These include periodic Low Vision Exams and updates of Low Vision Aids.
- Provision of aids for the blind to ensure safety and quality of life issues
- VIST newsletter is used for information and contact.
- VIST volunteers call and look for "red flags" by interviewing using a script that emphasizes Risk questions.

South Texas Risk Management Model
Decision making based on clinical indicators

- BROS does periodic visits based on VIST referrals, other clinic referrals, input from VIST volunteers, or responses based on Newsletter articles that emphasize some aspect of care and concern. These are usually tied to Risk issues.
- Return trips or first trips to BRC as clinically indicated.
- Surveys are conducted to obtain veteran feedback
- Mailings and updates on special interest items and benefits are ongoing.

Considerations In Making Blind Rehab Center Referrals

The following clinical indicators are requirements needed for a veteran to be worked up for an application to a BRC:

- Legally blind
- Functionally blind*
- Medically stable
- Cognitively prepared for hospital based training away from home environment
- Needs cannot be met locally
- Reasonable training goals
- Willingness to attend
- Ability to be away from home successfully
- Veteran able to travel to blind rehab center

Practical clinical indicators:

- BRC being able to meet veterans support needs
- Veteran is having severe adjustment to blindness issues
- Veteran is overly dependent on family and friends
- Veteran has a progressive eye disease that will lead to total blindness
- Veteran lives an active life involved in the community and can no longer do this due to problems with O&M
- Veteran lives in an area not easily accessible for local service delivery
- No local services in an area
- Veteran lives alone and without a comprehensive program will likely require institutionalization
- Veterans with severe field restrictions causing safety concerns during mobility
- Veteran travels and says there is a desire to be as independent as possible

South Texas Risk Management Model
Decision making based on clinical indicators

- Veteran would benefit from more intensive work with low vision devices and aids for the blind
- Veteran is interested in getting a guide dog and needs comprehensive program first
- Veteran requires intensive training using the long cane
- Veteran would benefit from training in isolation from family based on cultural, role, or relationship issues

* Functionally blind may be substituted for Legally Blind as eligibility criteria. Cases need to be reviewed by VIST and BRC.

Clinical Indicators Factors that could rule out BRC training experience

- Veteran unwilling to attend a BRC
- Local services (which could address needs if available)
- Training goals are minimal and could be addressed locally.
- Moderate to severe cognitive deficits
- Moderate to severe dementia
- Complicating medical conditions involving treatments that do not allow for training or a viable window for training
- Inability to travel to BRC (fear of flying, etc)
- Incontinence
- Treatable eye conditions (see examples below)
- Severe PTSD (to be determined case by case)
- Severe psychological disorders
- Highly communicable diseases (see examples below)
- Family does not support veteran's attendance
- Desire to use the BRC as respite
- BRC unable to support patient's need (see example below).
- Loss of placement (see example below)
- Loss of in-home provider services
- Veteran is primary care provider (normally for spouse, could be other)
- A referral to meet a Coordinator's needs
- Computer upgrades
- Proven functional computer users

Practical clinical indicators to not refer a patient to a BRC:

- Veteran agrees to go only to please the Coordinator
- Veteran needs training on simple to use devices
- Coordinator has to withhold prosthetics to coax the veteran into attending

South Texas Risk Management Model
Decision making based on clinical indicators

- Veteran is only agreeable to be placed on a waiting list with no real commitment to actually attend
- Continued substance abuse
- History of significant non-compliance
- Ongoing active legal and social issues
- Veteran agrees to go to get dental work done
- Veteran agrees to go based on being presented misleading information
- Veterans who avoid the Coordinator because of the attempt to get them to agree to attend
- Veterans who are observed to be coping and adjusting well

General Operational definitions

BRC unable to care of special needs: It is conceivable that a veteran cannot be served by a specific BRC for numerous reasons. Dialysis is the most logical case.

Communicable diseases: TB, an airborne disease is the most obvious example. Diseases such as Hepatitis and AIDS can be avoided by use of Universal Precautions and do not fit into this category. However, often legal blindness does not occur until late in the progression of AIDS and at that time there are usually multiple accompanying medical issues.

Complicating Medical Condition: The best example of this may be end stage renal disease or severe end stage glaucoma that is being actively treated. The veteran may have numerous appointments space closed together not allowing a window of training at a BRC. This may speak to the need of a continuum of treatment options.

Computer upgrades: Upgrades should be done in the field if possible. The new Prosthetics National Contract will address local services to accommodate this.

Desire to use the BRC for respite: At times family care providers feel the need for a period of rest for themselves. BRCs should not be utilized for this purpose.

Incontinence: This is a twofold problem. First, the BRC needs to be able to address the details involved with incontinence. Second, there is the concern for the veteran and his or her self esteem related to this problem and interacting in a group setting.

South Texas Risk Management Model
Decision making based on clinical indicators

Inability to travel: Physical concerns, anxiety attacks, panic disorders, etc. related to travel could negate a veteran's ability to attend a BRC. Current fears about terrorism will likely stop some individuals. These concerns may be magnified in veterans with PTSD.

Local resources available: In a continuum of care, services where there are developed service alternatives some veterans' needs can be met locally. As reimbursement for services becomes more abundant in future years there will be a wider array of community service providers in the private sector.

NOTE: The notion of reimbursable service for the visually impaired is a shift in paradigm. The new Medicare (CMS) bill could include funding of low vision services. As of now it looks as if CMS will initially only Blind Rehab Specialist, Physical Therapists and Occupational Therapist as provider disciplines. The bill currently sits in a joint House - Senate resolution committee ironing out the differences in the Medicare bill.

Loss of placement: This sounds minor, but it is a major consideration. If a veteran is in an excellent placement (nursing home, assisted living, etc.) and leaving to go to a BRC threatens retention of the bedspace their needs to be an analysis of the benefits versus the potential loss of the placement.

Loss of provider services: Great care must be taken to make sure a veteran will not lose in home provider services by going to a BRC. These services are often hard to obtain and require long waits to establish. Veterans receiving these type services probably could not remain in their homes without them. Agency rules may terminate services if there is a break in the need. Again, this may sound like a minor consideration, but service providers may be critical to independent living.

Minimal training goals: This is a clinical judgment on the part of the VIST Coordinator, BROS, the veteran, and the family. The bottom line should be does the patient's real needs fit into the framework of weeks away from home in a hospital based setting or is there a need for task specific intervention in the actual community or home environment. It is important that the VIST Coordinator sits down with the veteran and family to determine the nature of the problem and the best intervention strategy.