**Self-Report Assessment of Functional Visual Performance (SRAFVP)**

**Toolkit**

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**READ ME FIRST!**

This toolkit is a compilation of resources contributed by various LVR professionals interested in meeting the latest Medicare challenge of using g-codes to demonstrate impairment and progress in therapy. You are free to use the information and forms included in the toolkit as needed to help your practice and to share it with others. We only ask that you abide by the copyright acknowledgement request for the SRAVFP.

***DISCLAIMER:*** We are low vision professionals but we are NOT Medicare experts. All information about using the g-codes for Medicare documentation is based on our best efforts to understand the process BUT our advice won’t stand up in a court of law and your Medicare provider has the final say. So if challenges arise with your Medicare provider- you must resolve your issues with them on your own!

***Copyright/Permissions***

The SRAFVP guide and profile forms are copyrighted. You have permission to freely use the assessment and form in your practice with the following restrictions.

1. You may alter the format of the form to fit your needs but you must credit the authors of the form-e.g.- the Occupational Therapy Departments of the University of Alabama at Birmingham, Washington University, and the University of Florida.

2. You may not retitle the assessment or state or imply in anyway ownership or authorship of the assessment.

3. You may distribute the assessment to others as long as you acknowledge the authors as the source of the form.

We are interested in hearing about your experiences in using the SRAFVP to select g-codes. The use of outcome evaluations to quantify patient performance and progress is here to stay and we want to develop the best tools to demonstrate changes in our low vision clients. Please email Mary at [warrenm@uab.edu](mailto:warren@uab.edu) with feedback or comments about the SRAFVP.

Thanks!

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**Introduction**

The Self-Report Assessment of Functional Visual Performance (SRAFVP) is an ADL assessment that focuses on 38 vision-dependent ADL tasks. The assessment was developed in 1995 as a collaborative project between the occupational therapy departments at the Eye Foundation, University of Missouri-Kansas City and Washington University with a grant from the American Occupational Therapy Foundation. The purpose of the project was to develop a valid and reliable assessment that would provide clinically useful and quantifiable information about a client’s ability to complete vision-dependent ADL tasks. The goal was to create an assessment that would be easy to administer and interpret and would assist the therapist to develop appropriate occupation-based goals for the client.

***Test Psychometrics***

Content validity for the assessment was established using a 2-step process. A panel of six occupational therapists with clinical experience in low vision rehabilitation developed a list of vision-dependent ADL tasks commonly encountered in practice, a set of item descriptions, and a five item rating scale. A separate panel of five experts in low vision rehabilitation and instrument development reviewed and verified the accuracy of the task items and the rating scale. The assessment was then administered to a sample of older adults with low vision due to age-related eye disease. Seven trained occupational therapists administered the SRAFVP in the participant’s home or clinic. The therapist used an interview format to administer the test. The therapist described the item to the participant using the item description and asked the participant to rate the item using the scale. Participant response for each item was recorded; family members could be present but were not permitted to comment during the interview. The interview process was typically completed within 20 minutes. To establish inter-rater reliability, two therapists simultaneously rated the client during administration of the test to 25 participants. Inter-rater reliability of .97 was established.

Data was collected during a six-month period in 1996 on a convenience sample of 102 older adults with low vision from age-related eye disease recruited from the two low vision programs. All of the participants resided in the community; 89% lived alone or with a spouse. Seventy-one percent of the sample was over age 75; 71% were women and 78% were Caucasian. Macular degeneration (66%) was the most prevalent reported eye disease followed by diabetic retinopathy (18%), glaucoma (11%) and cataracts (6%). Some patients reported more than one eye condition. Seventeen percent of the participants had dual sensory impairment (low vision and hearing impairment).

A Maximum Likelihood of Fit factor analysis with orthogonal oblique Harris-Kaiser rotation analysis was used to establish content reliability. The analysis revealed 4 clear constructs with an overall Cronbach’s Alpha of .87. The constructs and Cronbach Alpha were (1) functional reading (near vision), .86; (2) meal preparation (intermediate vision), .84; (3) functional mobility (distance vision), .87 and (4) functional writing (eye-hand coordination), .84.

Construct validity and reliability was established using the Rasch rating scale model. The SRAFVP was well matched to the sample and the items provided good person separation reliability. The instrument showed unidimensionality and satisfactory model fit. Acceptable levels of internal construct validity were confirmed (mean [M] item fit = 1.00, standard deviation [SD] = 0.34; M person fit = 0.98, SD = 0.29). The SRAFVP demonstrated satisfactory reliability (person reliability = 0.88; person separation = 2.70; item reliability = 0.98; item separation = 6.59. The five rating levels on the original form were collapsed to three following analysis because participants were not using all rating levels in a statistically expected manner. Rasch analysis also ordered the ADL tasks according to level of visual difficulty from easy to hard to create an assessment free of sample bias. This means that difficult items on the assessment for one client are at the same level of difficulty for another client; likewise, the easy items for one client will be the easier items for another client. The Rasch model uses mathematical formulas to calculate the probability that a person will obtain a certain rating on an item of a certain difficulty. In doing so, it makes it possible to create an interval scale of scores for both the difficulty of items and the ability of the persons tested so that item ratings can be summed to produce a numerical score.

***Using the SRAFVP to Establish a POC and Show Improvement in Therapy***

By ordering ADL tasks according to their level of visual difficulty, the SRAFVP provides a visual “recovery map” that shows the client’s level of ability to complete vision-dependent ADL tasks. The therapist can use the scoring pattern created on the test form to identify the “just right” ADL challenge and establish the most appropriate ADL goals for the client. By choosing the tasks that are most achievable, the therapist is more likely to be able to show a % improvement in the client’s score on the SRAFVP and assign a higher G-code rating at discharge.

The test can be formatted various ways to show the recovery profile. Four versions of the assessment (A-1, A-2, B, C) are available, each with different formatting of the items. The forms are stored in separate pdf files for individual download

***Version A-1 and A-2****:* This version lists the 38 test items in descending order from most difficult to easiest to complete. The format provides a comprehensive “recovery profile” that shows the client’s overall level of ability to complete vision-dependent ADL tasks. This is useful when the therapist will be addressing a wide range of ADL limitations.

***Version B***. This version divides the items into three subscales: reading (12 items), eye hand coordination (22 items) and mobility (4 items) based on research completed by Mennem, Warren & Yuen (2009). On the form, the items within each category are ordered from the most to least difficult-to-perform based on the Rasch analysis of the original data. This ordering process provides an individual recovery map for each subscale. The Mennem et al. study evaluated internal consistency of the subscales using Cronbach alpha and convergence validity using the Pearson-Product Moment correlation. The Cronbach alpha coefficients showed high internal consistency and provided support that the items within each subscale measured the same construct; significant correlations between the subscales showed that they were related and measured vision dependent ADL.

***Version C***: This version orders the items within the broad ADL categories used in the original research. On the form, the items within each ADL category are ordered from most to least difficult-to-perform based on the Rasch analysis of the original data. This ordering process provides an individual recovery map for each subscale.

***References***

# Velozo, C.A., Warren, M., Hicks, E, Berger, K.A. (2013). Generating clinical outputs for self-reports of visual function. *Optometry & Vision Science, 90* (8), 765-775.

Mennem, T. A., Warren, M. & Yuen, H.K. (2012). Preliminary validation of a vision-dependent activities of daily living instrument on adults with homonymous hemianopia. *American Journal of Occupational Therapy, 64*,(4) 478-482.

**General SRAVFP Administration Instructions**

The SRAFVP consists of two components: a self-report assessment and an optional observational assessment of selected ADL tasks (found on SRAFVP form A-1 and pages 3-4 of this document). The self-report assessment should be completed first during an interview with the client. If the client’s answers to the interview questions cause you to suspect that he or she is under or over estimating his or her ability, then the items on the observational assessment can be used to verify the client’s responses. Before administering the self-report assessment, familiarize yourself with the descriptors for each ADL task.

1. Administer the assessment in a quiet environment free of distractions. The assessment should take approximately 20 minutes to complete.

2. Explain the rating scale to the client. You may want to prepare a “cheat sheet” with the words: *unable, difficult, independent* printed on it to remind the client of the rating scale.

3. Describe each ADL task to the client and ask the client to rate his or her ability to complete the task. Circle the corresponding number next to the task description on the profile. If the client does not complete the task or it is not applicable, do NOT circle anything.

4. Instruct the client to complete tasks on the observational assessment as needed to confirm the accuracy of the client’s responses on the self-report assessment.

5. After all tasks have been rated, observe the pattern created on the profile and interpret the client’s performance using the information in the next section.

**Scoring the SRAFVP**

The SRAFVP provides a score of independence in vision-dependent ADL tasks. This is typically a total score of all items used, but sub-category scores can also be calculated using the same algorithm. Whether obtaining a total score or category scores, the process is the same. Steps for score calculation are located at the end of each form (G-A-1, G-A-2, G-B, G-C) and are detailed below.

**Step 1:** Determine the possible points earned

* This is a total of the number of items used multiplied by the highest possible score for each (2). Include all NA items (if using only specific categories, total all items in each category used).
  + **(# of items used)\_\_\_\_\_\_ x 2 = Total possible points**
* Examples:
  + All items: 38 x 2 = 76
  + Form G-B: Eye hand coordination category only: 22 x 2 = 44
  + From G-B: Reading only: 12 x 2 = 24
    - NOTE: If assessing only reading, use the reading section of form G-B (vs. form G-C) as it contains all reading items including several from different categories found on form G-C
  + Form G-C: Personal care, Meal prep, Telephone, Leisure & Mobility: 20 x 2 = 40

**Figure A: For the remaining steps, the following example (Reading category, form G-B) will be used as an illustration**



Not able to see the TV guide on his TV well enough to see the channels. Is able to read large & medium headlines on newspaper but not articles. Can read packages & labels using HHI when item is high contrast. Difficult reading fine print on bills & following rows/columns. Uses a Jitterbug cell phone & has numbers programmed in contacts. Has a talking watch & is able to see LCD clock on microwave

**Step 2 :** Total up the NA items

* (# of NA items) x 2 = \_\_\_\_\_
  + When using the entire form, total up all NA items
  + When using only one or more categories, total up only the items marked NA in the categories being used
* Figure A: 1 NA item: 1 x 2 = 2

**Step 3:** Determine the adjusted total

* Subtract the NA score (step 2) from the total possible points (step 1)
* (**Total possible points) – (Total NA items) = Adjusted total**
* Figure A: 24 – 2 = 22

**Step 4**: Client’s total score

* Count up the number of 1s and number of 2s earned
* **(# of 1s) + (# of 2s x 2) = Total score**
* Figure A: # of 1s = 5, # of 2s = 3
  + 5 + (3x2) = 11

**Step 5**: Determine the SRAFVP score

* Divide the total score (step 4) by the adjusted total (step 3)
  + Total score ÷ Total score = \_\_\_\_\_\_ (SRAFVP score)
* Figure A: 11 ÷ 22 = 0.4583

**Step 6:** Convert the SRAFVP score to a percentage (level of independence in assessed vision-dependent ADLs)

* Multiply the SRAFVP score by 100 & round to the nearest full %
* **SRAFVP score (step 5) x 100 = % (round)**
* Figure A: 0.4583 x 100 = 45.83, rounded = 46%

**To determine the associated Functional Reporting (G-code) modifier follow the steps below.**

**Step 7: Determine the functional reporting level**

* **100 – SRAFVP% = % of impairment for functional reporting**
* Figure A: 100-46 = 54% (CK: 40-59%)

**Instructions for Using the Calculated SRAFVP Spreadsheet**

Dr. Sunness created this spreadsheet using SRAFVP form C. The spreadsheet is saved as an Excel Template so that the formulas and items cannot be overwritten.

The spreadsheet automatically calculates the number of relevant measures, the composite score, the percentage of disability and the initial g-code levels

To use the spreadsheet template:

1. On the SRAFVP form located on the left side of the spreadsheet.
   1. Enter the patient name, date, and whether it is an initial, progress note, or discharge assessment in column B
   2. Enter the patient’s ratings for the items in column C using the numerical ratings. Enter “n” for non applicable items.
2. When the rating column is completed, the embedded formulas in the spreadsheet automatically calculate the number of relevant measures, the composite score, the percentage of disability and the initial g-code levels. These are printed out next to the middle and far right SRAVFP forms on the spreadsheet
3. The middle SRAVFP form shows the items receiving less than a 2 rating on the form and indicate the areas to be addressed as **Goals of Treatment** on the plan of care.
4. The SRAVFP form on the right hand side of the spreadsheet shows the **Full Table** –e.g. the fully completed form.
5. Save the spreadsheet as an Excel worksheet or as a PDF (see examples) with the patient’s name.
6. When you print out the saved spreadsheet, only the middle and right-side SRAFVP forms will print. Columns F-N, which correspond to the item order on G-A-2 form (all tasks ordered by difficulty, not divided into functional areas) are not included on the print out, but are available for research purposes. *Note:* You may need to reduce the scale of the spreadsheet to 90% to get the g-code print out to align with the SRAFVP forms and create a 2 page print-out

Source:

Hoover Low Vision Rehabilitation Services

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**Functional Reporting (G-Codes)**

The information contained in this section is based on policies detailed in the Medicare Benefit Policy Manual (100-02) and MLN Matters: MM8005 Revised. The information reflects use of the Self-care code set, the most relevant for low vision services.

*Practioners should always check with their jurisdiction A/B MAC to determine if additional policies have been determined for their region.* *Commercial insurance may not require, or may have a different policy for functional reporting; consult commercial insurances individually for direction*.

At evaluation

* Report G8987 and G8988, along with the related severity modifiers to report the current status and projected goal status.

Progress Report

* Report G8987 and G8988, along with the related severity modifiers to report the current status and projected goal status.

At discharge

* Report G8988 and G8989, along with the related severity modifiers to report the projected goal and discharge status.

One-Time Therapy Visit

* When a beneficiary is seen and future therapy services are either not medically indicated or are going to be furnished by another provider
* Report for the date of service:
  + G8987, G8988, G8989 (current status, goal status and discharge status) along with corresponding severity modifiers on each code line

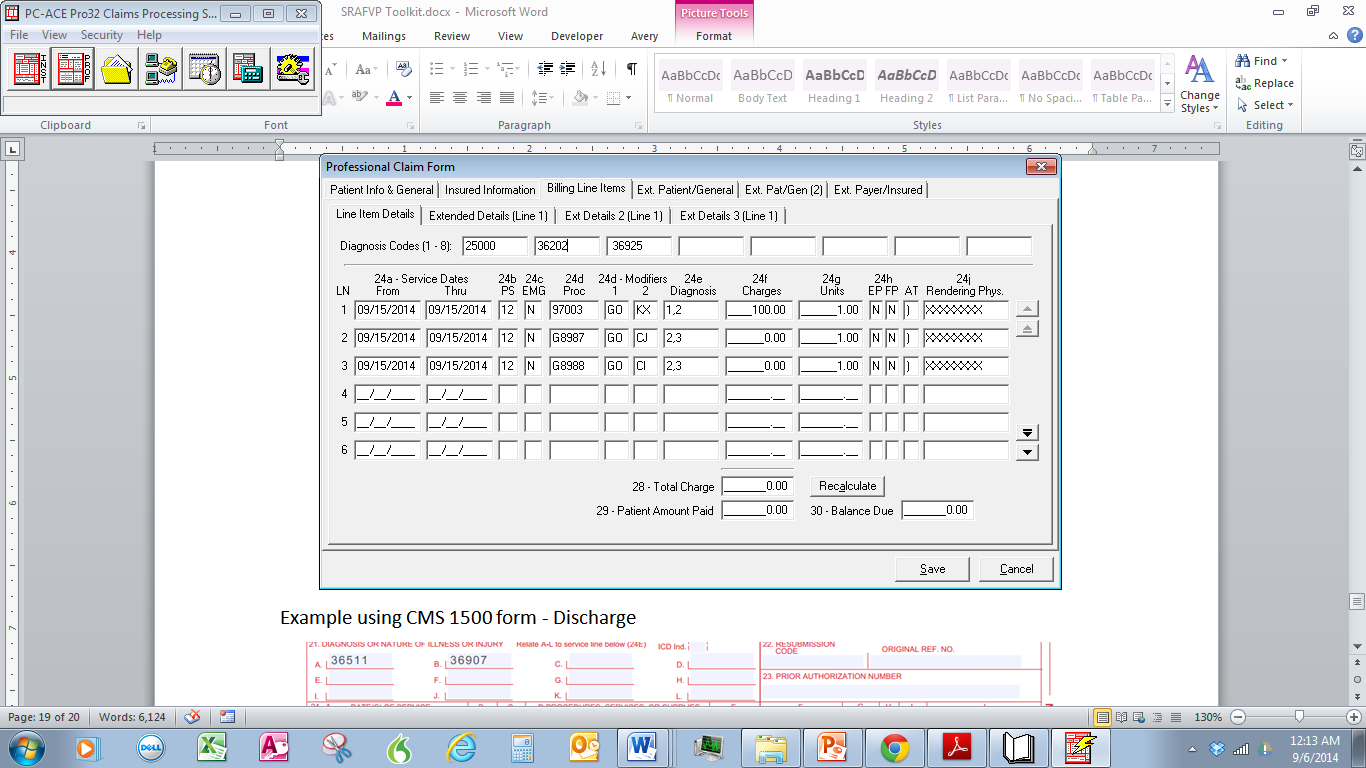
*The GO (OT) modifier must also be included on all functional code reporting lines.*

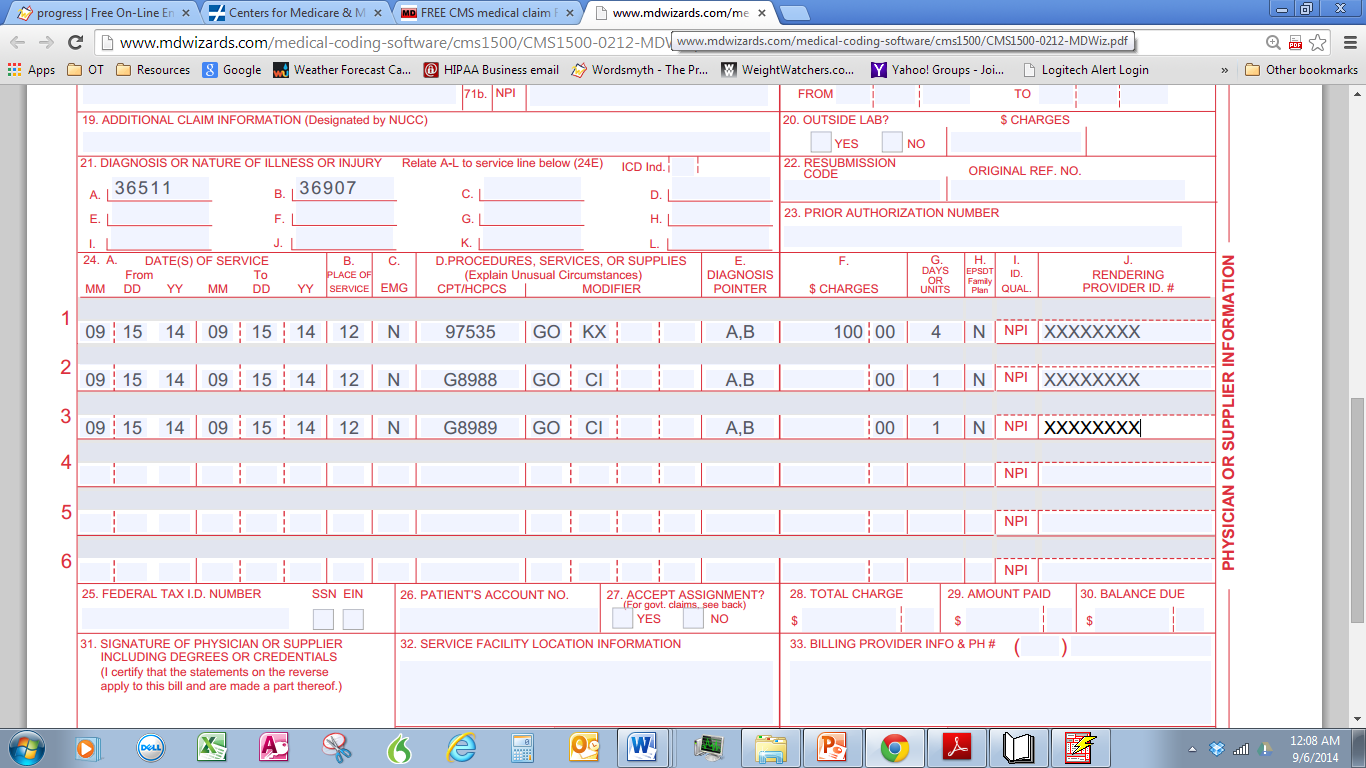
|  |  |
| --- | --- |
| **Modifier** | **Impairment Limitation Restriction** |
| **CH** | 0 % impaired, limited or restricted |
| **CI** | 1% - 19% 1 impaired, limited or restricted |
| **CJ** | 20% - 39% impaired, limited or restricted |
| **CK** | 40% - 59% impaired, limited or restricted |
| **CL** | 60% - 79% impaired, limited or restricted |
| **CM** | 80% - 99% impaired, limited or restricted |
| **CN** | 100% impaired, limited or restricted |

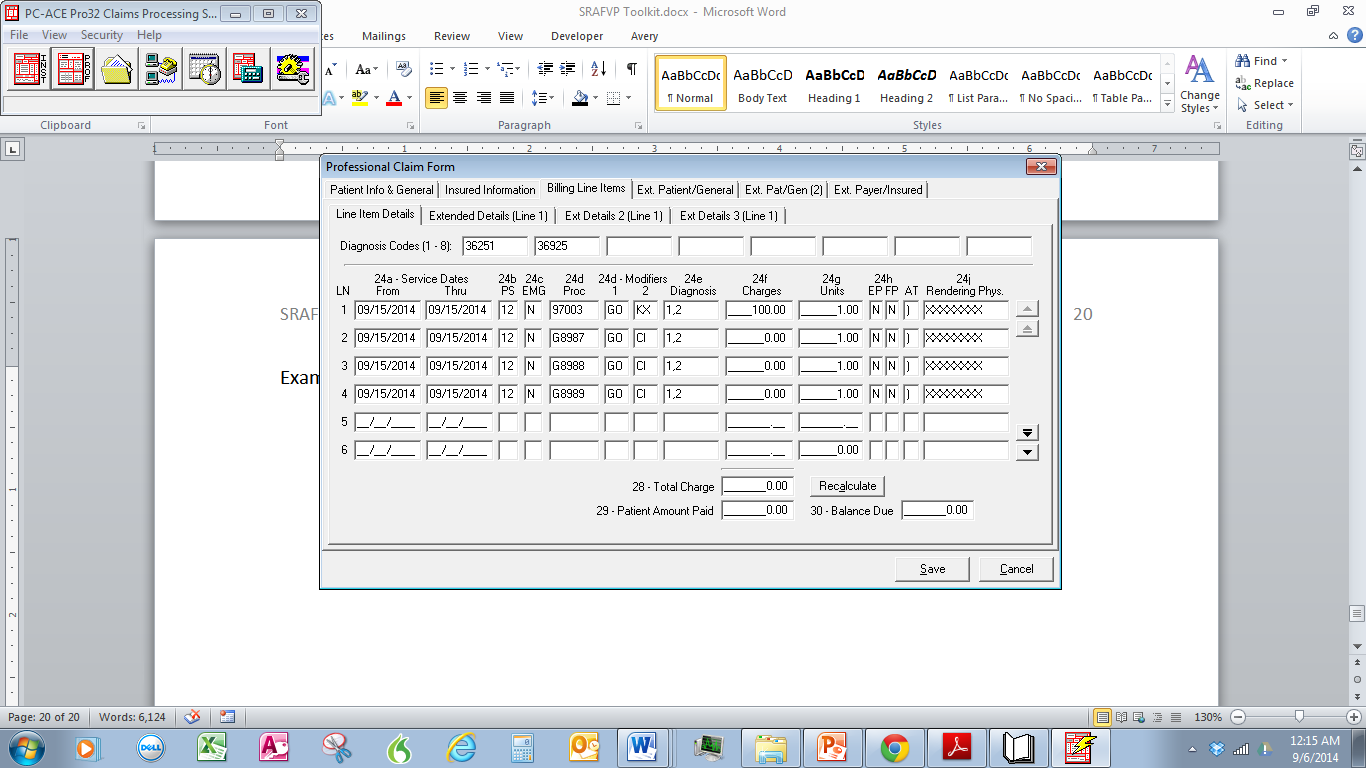
Example using CMS 1500 form - Evaluation



Example using PC-ACE Pro32 – Progress Note



Example using CMS 1500 form - Discharge

Example using PC-ACE Pro32 – One Time Visit

References

Department of Health and Human Services, Centers for Medicare & Medicaid Services. (December 21, 2012). Functional Reporting. *Medicare Benefit Policy Manual*, Chapter 15, Section 220.4, pp. 192-194. Downloadable from: <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf>

**Using the SRAFVP for Functional Reporting (G-Codes)**

The SRAFVP provides three advantages for assigning the correct G-code for the client.

1. Because rating numbers on an interval scale represent an equal distance between each rating category, they can be summed to produce a meaningful composite score. This makes it possible to accurately calculate the percentage of disability needed to select the most appropriate G-code for the client. For example, 2 is the best possible rating a client can report on each of the 38 test items; 2 x 38 = 76. Therefore a perfect composite score (e.g. NO reported disability) on the SRAFVP is 76 points. A client with a composite score of 15 would have a percentage equal to 20% of the total possible points and therefore would demonstrate 80% impairment and be assigned the G-code- CM based on the table below (reproduced from the CMS website).

|  |  |
| --- | --- |
| Modifier | Impairment Limitation Restriction |
| CH | 0 percent impaired, limited or restricted |
| CI | At least 1 percent but less than 20 percent impaired, limited or restricted |
| CJ | At least 20 percent but less than 40 percent impaired, limited or restricted |
| CK | At least 40 percent but less than 60 percent impaired, limited or restricted |
| CL | At least 60 percent but less than 80 percent impaired, limited or restricted |
| CM | At least 80 percent but less than 100 percent impaired, limited or restricted |
| CN | 100 percent impaired, limited or restricted |

2. G-codes are assigned based on the client’s overall level of impairment in self-care. Because the 38 items of the SRAFVP cover a wide range of vision dependent ADLs, calculation of the percentage of the composite score will accurately reflect the required overall level of functional impairment within the primary OT category of self-care.

3. The therapist can score only those items that the client completes and adjust the composite (e.g. total) score accordingly to calculate the percentage and assign the G-code. This is important because many older adults give up certain ADL tasks by choice. For example, a visually impaired older gentleman (lets say my father in-law) has never cooked a day in his life and wouldn’t know a microwave oven from a toaster. Now suddenly widowed, he has chosen to eat all of his meals in the dining room of the residential facility where he lives. To accurately calculate the g-code for my father in-law, the therapist would remove 14 points (7 items x 2) from the composite score of 76 and calculate the percentage score based on a total composite score of 62.

**Instructions for Using the SRAFVP to Create an**

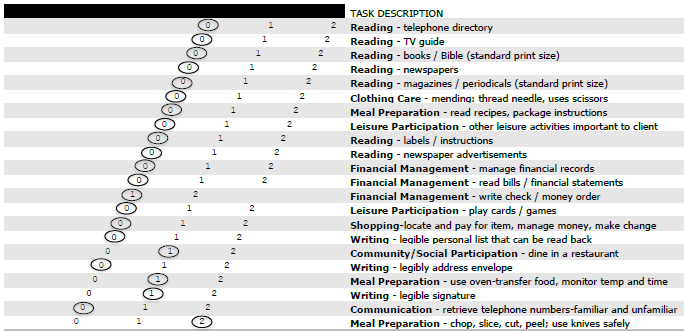
**Intervention Roadmap**

**This explanation shows how version G-A‐1 and G‐A‐2 can create a roadmap for intervention.**

## How the Form Works

The SRAFVP profile does not look like your typical assessment form. Instead of listing ADL tasks by categories, the tasks are listed by level of visual difficulty, thus the tasks at the top of the form are more visually demanding than those at the bottom of the list. Using Rasch analysis to order the ADL tasks according to their level of visual difficulty enables the SRAFVP to be a sample-­‐free assessment. Sample-­‐free means that test items are free of sample bias: difficult items on the assessment for one client will be at the same level of difficulty for another client; likewise, easy items for one client will be the easier items for another.

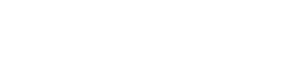
Because of this design, the SRAFVP is able to provide a “recovery profile” that shows the client’s overall level of ability to complete vision-­‐dependent ADL tasks. Figures 1 and 2 illustrate profiles for clients with low and moderate visual abilities respectively. As the figures show, a client with less ability to use vision (Figure 1) will score lower on tasks that are more visually difficult than a client with greater ability to use vision (Figure 2). Being able to see where a client fits on the profile shows the therapist the next expected steps in recovery of ADL independence. Thus the completed profile provides a roadmap for intervention, enabling the therapist to select ADL tasks that will provide a “just-­‐right challenge” to promote greater ADL independence. It also allows the therapist to measure progress because as the client responds to the OT intervention, his/her position on the profile should change.

**

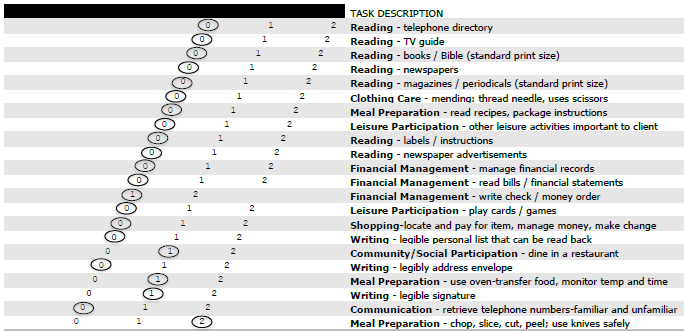
*Figure 1: Profile for Client*

*with Low Visual Ability*

Client is unable



Client is unable

**

Client has some

difficulty

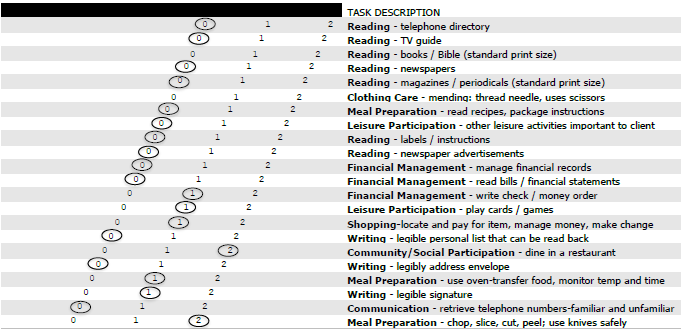




Client has little

difficulty

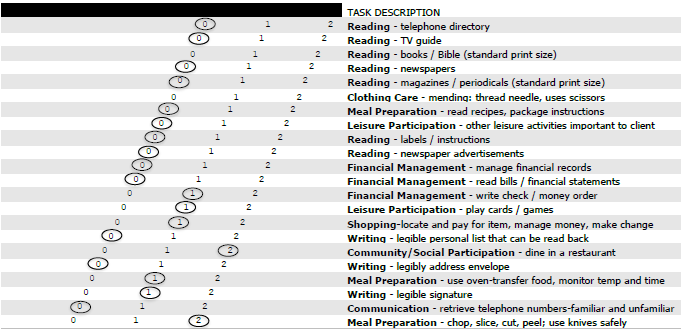
The scores on the profile in Figure 1 indicate that the client is able to independently complete several ADL tasks that require less visual ability (dressing and grooming); needs some assistance for tasks that involve seeing larger details such as a telephone key pad or writing and is unable to complete tasks that require seeing small details such as reading a newspaper or mending. Note that the client does not need to complete all items on the instrument to reveal their profile. In the above example the client did not respond to “clothing care – laundering” or “leisure – other.”



*Figure 2: Profile for Client*

*with Moderate Visual Ability*

Client is unable



Client has some

difficulty



Client has little

difficulty

The scores on the profile in Figure 2 indicate that the client is able to independently complete ADL tasks that require less visual ability (dressing, grooming, aspects of meal preparation): needs some assistance for tasks that involve seeing larger details such as writing and money management and is unable to complete tasks that require seeing small details such as reading a newspaper or mending. In comparing the two figures, one can see that the client with moderate visual ability is able to independently complete a larger number of tasks that require less vision than the client with low visual ability. Both clients are unable to independently complete tasks that require high visual ability.

## Using the Form to Establish Goals

The middle section of the profile in Figures 1 and 2 represent the area of transition between tasks that are already within the client’s capabilities and tasks that are too visually difficult for the client. Tasks at this level represent the “just right” challenge for the client because with some intervention, the client should become independent in these tasks. Therefore these are the tasks for which intervention goals should be established first. The tasks above this level are very difficult for the client, but with a good intervention, time and resources the client may be able to become independent. Improving the client’s ability to complete higher-­‐level tasks should have the effect of improving independence on all of the tasks below them on the profile. Therefore, if the client has the motivation and resources and you have the time, it is appropriate to set goals for the higher-­‐level tasks.

**Case Example: Mabel Moderate**

This section describes the SRAFVP profile of a typical client referred for low vision rehabilitation and demonstrates how the profile can be used to establish and prioritize goals for the client.

## Background Information

Mabel Moderate is an 83 year-­‐old woman with age-­‐related macular degeneration (AMD). She was diagnosed with the dry form of AMD three years ago. She still has dry AMD in her right eye but six months ago she developed wet AMD in her left eye and has experienced a significant loss of vision in that eye over the last two months. Her current Snellen visual acuity is 20/160 in her right eye and 20/ 250 in her left eye. She has a central scotoma in both eyes. Her right eye is her dominant eye and she has a moderately well established PRL (preferred retinal locus) located superiorly to the scotoma. She is able to locate the PRL but has difficulty maintaining fixation and using the PRL for tracking and gaze shift. Her left eye is her non-­‐dominant eye and she has poorly established PRL in this eye to the right of the scotoma. She has moderately impaired contrast sensitivity in both eyes.

She has very few health concerns other than her vision. She reports mild arthritis in her knees and back when the weather is “acting up.” She takes medications for arthritis, hypertension, osteoporosis, and to lower cholesterol levels.

Mabel lives in her own home. Until last month, she shared her home with Wally, her husband of 60 years. Wally died suddenly of a massive heart attack and Mabel reports that her “independence died with him” as he was the one who took care of all of the tasks that she couldn’t see well. She has outlived her son and has only one relative in the area, a niece who lives 80 miles away and has been battling breast cancer. Her niece visits her every two weeks but Mabel doesn’t want to impose on her. Mabel very much wants to continue to live in her own home-­‐she has so many memories of her life with Wally there and she doesn’t want to give that up.

## Mabel’s Performance on the SRAFVP Profile

Mabel’s SRAFVP profile is Figure 2. Below is a description of her answers for each of the boxes on Figure 2.

*The lowest box at the bottom of the profile-­‐tasks requiring less visual ability:*

*Basic ADLs (all rated as 3)*: Mabel reports that she has figured out strategies to complete grooming, dressing and bathing using simple adaptations such as a magnifying mirror to apply make-up, handrails on the toilet and in the shower, and better lighting in the bathroom. She doesn’t always see food clearly on her plate when eating out but has no difficulty eating at home or with close friends

*Medication management (rated as 2)*: Mabel reports that she takes four medications including daily medications for arthritis, hypertension and high cholesterol. She also takes a weekly osteoporosis medication. She takes two medications in the morning and one at night. Before Wally died, he dispensed her medications. After Wally’s death she took a friend’s suggestion and started using a pillbox to organize her medications but she feels uncomfortable with the task. She has difficulty reading her medication labels and the bottles and the pills look very similar-­‐she is afraid of mixing them up. Her neighbor has volunteered to fix a weekly pillbox for her but she has refused. Instead she fixes the box and lets her neighbor check her work but she doesn’t like that solution because she feels that it imposes on her neighbor.

*The middle box on the profile-­‐tasks in the transition zone:*

*Meal preparation (rated as 2 on use of oven)*: Mabel has been an avid lifelong cook and has many cookbooks and recipes. She has lived in her home for 60 years and is very familiar with her kitchen. Last year Wally installed a large fluorescent light and under counter lighting.

She feels comfortable completing most aspects of meal preparation but has difficulty setting the correct temperature on the oven so Wally always set it for her. Last week she set the oven at 450 instead of 350 and burned three pies she had made for a church luncheon. She had to ask her neighbor to buy her some store bought pies and now, even though she is famous for her fruit pies, she plans to retire from pie baking.

*Reading time pieces and using the telephone (rated as 2)*: Mabel reports that she didn’t bother with a watch or a clock when Wally was around as he was always with her and let her know the time. Now when she goes out with friends to events she feels embarrassed to ask what time it is. She also isn’t sleeping well and when she wakes up in the middle of the night she often wants to know what time it is but can’t see her bedside clock. She also has difficulty using the telephone accurately. Wally had always dialed the telephone number if she needed it and now she finds that she often dials incorrect numbers, which is embarrassing.

*Writing (rated as 2):* Mabel reports that her handwriting is “a mess.” She tends to drift up and down on a line and crowd her letters and if she lifts her pen off of the page she often comes down on top of a word she’s just written. She doesn’t complete much written correspondence but she does send birthday and anniversary cards to a wide range of acquaintances. Wally always addressed the cards, wrote a brief note and showed her where to sign. She wants to be able to keep up her correspondence so that her friends don’t worry about her.

*Making change (rated as 2)*: Mabel is able to identify coins and paper money at home under bright lighting but when she goes shopping, she has difficulty seeing her money and feels intimidated, thinking that she will inconvenience the other customers. To compensate, she carries large bills with her and usually ends up with a lot of unwanted change. If she knows the cashier, she’ll hand over her coin purse and have the cashier take what is needed. She is uncomfortable with this strategy and feels very self-­‐conscious and a bit nervous about handing over her purse in public.

*The top box on the profile-­‐tasks of great difficulty*:

*Reading (all rated as 1)*: Mabel reports that she has difficulty with all tasks that require reading. She had been an avid reader and had belonged to a book club, which she gave up 2 years ago. She also belonged to a Bible study, which she completed with Wally’s help (he read the assigned lesson to her) and she would like to be able to continue to participate in this activity. She had also read the newspaper daily (especially the obits and the society page) and subscribed to Readers Digest and Guideposts. Wally also faithfully read these to her and she misses the intellectual stimulation she received from them. Although she has an expensive magnifier that Wally bought her, she is unable to use it to read articles, look up a telephone number or read instructions, labels, recipes and appliance dials. It wasn’t a challenge when Wally was living because he read for her but now she needs to be able to read on her own.

*Financial/Money Management (rated as 1)*: Mabel reports that this is her greatest concern. Wally paid all of the bills and managed their finances. He was good about keeping her informed so she knows when bills need to be paid and what income to expect BUT she is having significant difficulty reading bills, making out a legible check and making entries into her check register. She doesn’t want to burden either her niece or her neighbor with this activity.

*Shopping (rated as 1)*: Mabel’s reading challenges spill over into shopping. She reports that she has difficulty reading labels, ingredients, and expiration dates. She gets a ride to the grocery store with her neighbor but hates to rely on her to also locate items. She has returned from shopping with several items that she didn’t want and recently paid $4.35 for bacon that was past its expiration date and rancid.

*Mending (rated as 1)*: Mabel used to sew all of her own clothes and was very handy with a needle and thread but now she is unable to thread a needle, sew on a button, or fix a tear. She reports that she can rely on her neighbor for help but she doesn’t want to burden her because she does so much for her already.

## Using the Profile to Develop an Intervention Plan for Mabel

*Tasks at the least level of difficulty*:

Mabel’s ability to independently complete medication management should be easily addressed by developing a strategy to mark/label her medications so she can identify them accurately. One session should accomplish this goal.

*Tasks at the transition level*:

These tasks require greater ability to see small and low contrast detail, but with intervention, Mabel should become independent in all of these tasks. Marking/labeling strategies will be needed to help her identify money and the telephone key pad and set appliance dials accurately; she will need to learn to use a magnifier for spot reading (i.e. reading a single number, or word); she will need to be taught how to use her PRL to monitor the pen tip when writing and taught how to increase the visibility of the writing surface through use of bolded lines, good lighting and marking pens. Talking clocks and watches or large-­‐faced time pieces can be used to help her tell the time. Goals for these tasks should be attained within a couple of intervention sessions.

*Tasks at the highest level of difficulty*:

Reading continuous text again will only be possible if Mabel becomes proficient in using the PRL in her dominant right eye and is prescribed the right magnifier. Several different options for magnification will be needed to meet all of her daily needs which necessitates close collaboration with the prescribing eye physician to determine the best optical devices. Time will be needed to complete PRL training and to introduce her to an either an optical magnifier or electronic magnification or both. She will need to become proficient in both reading and writing to gain independence in financial management. Mending can be addressed with the use of a hands free magnifier. While it is possible for Mabel to attain independence in these tasks, more resources and time will need to be devoted to obtaining this outcome. Success will depend on various client and contextual factors including Mabel’s motivation, her general health and endurance and her financial resources. Several intervention sessions will be required to accomplish goals at this level.

# Reference:

Warren, M., Bachelder, J., Velozo, C. & Hicks, E. (2008). *The self‐report assessment of functional visual performance*. Occupational Therapy Departments: University of Alabama at Birmingham, University of Florida at Gainsvill

**SRAFVP Observational Assessment Tasks**

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| --- | --- |
| 1. | **Telephone directory** - Reads well enough to gain desired information |
| 2. | **TV guide** - Reads well enough to gain desired information |
| 3. | **Books/Bible** - Reads well enough to gain desired information |
| 4. | **Newspapers** - Standard print format; reads well enough to obtain enjoyment from activity |
| 5. | **Magazines/periodical** - Standard print format; reads well enough to obtain enjoyment from activity |
| 6. | **Mending** - Threads needle; accurately cuts with scissors and attaches a button or repairs a tear |
| 7. | **Read recipes** - Read recipes and/or package instructions accurately; within a reasonable amount of time |
| 8. | **Other leisure activities** - Rate ability to complete activity with sufficient speed, accuracy and effort to allow the activity to be enjoyable and rewarding |
| 9. | **Read labels/instructions** - Reads well enough to gain desired information |
| 10. | **Read newspaper advertisements** - Read well enough to gain desired information |
| 11. | **Manage financial records** - Maintains organized system for bills/financial statements, permitting quick document retrieval; makes legible entries into financial records |
| 12. | **Read bills/financial statements** - Locates and accurately identifies company, amount due and qualifying statements within a time period that the client determines reasonable |
| 13. | **Write check or money order -** Completes all areas of check/money order legibly enough for reading by another person; makes accurate, legible entries into check ledger; able to complete task within a reasonable amount of time in community environments |
| 14. | **Play cards/games** – Plays with others or solitary with sufficient speed, accuracy and/or effort that the game is enjoyable as a leisure pursuit |
| 15. | **Shopping** – Locates and selects desired item (either by visual identification or seeking appropriate assistance); accurately pays for item without assistance; **counts coins, bills and makes change**. Identifies, organizes and exchanges money accurately within a reasonable amount of time in community environments |
| 16. | **Writes personal list** – List or short note that client can read back days later; another person can read list |
| 17. | **Dine in a restaurant** – Selects food (reads menu or seeks appropriate assistance); locates table items and foods; easts food selection with acceptable level of neatness |
| 18. | **Address envelope** – Positions address accurately; able to stay on line; writing is legible to unfamiliar reader |
| 19. | **Use of oven** – Sets temperature accurately; tells when oven is on/off; monitors food accurately; transfers food in/out of oven safely without spillage |
| 20. | **Own signature** – Positions signature accurately; stays on line; signature is legible to unfamiliar reader; able to complete task both at home and in community as needed |
| 21. | **Retrieve telephone number** – Accurately uses address book, phone memory or own memory to recall familiar telephone numbers; uses telephone directory or directory assistance for unfamiliar numbers |
| 22. | **Chop, slice, peel** – Handles knives and peelers safely; cuts food into relatively uniform and appropriately size pieces; peels vegetable completely with minimal amount of waste |
| 23. | **Read watch** – Can accurately read at least one portable timepiece in home and community environments |
| 24. | **Laundering** – Accurately sets washing machine and dryer dials; measures dry and liquid detergents; accurately treats stains |
| 25. | **Read clock** – Has at least one clock that can be accurately read day or night |
| 26. | **Pour/measure liquids/dry goods** – Identifies correct measuring implement; fills cup/spoon accurately with minimal spillage |
| 27. | **Use of burners** – Sets desired temperature accurately; tells when burners are on/off; accurately and safely places pans onto burner; transfers food safely and without spillage |
| 28. | **Ascend/descend stairs** – Safely navigates stairs using safety features (rails, lighting, etc.) in familiar environments |
| 29. | **Use microwave** – Locates and selects settings accurately; transfers food in/out safely and without spillage |
| 30. | **Physical operation of telephone** – Accurately dials telephone number, sequencing or using speed dial in adequate time to successfully complete call |
| 31. | **Adjust to changes in walking surfaces** – Negotiates curbs, ramps and transitions between surfaces (carpet to tile, broken areas on sidewalks, etc.) without stopping, long hesitations, probing with cane or assistance |
| 32. | **Medication routine** – Identifies medications and takes accurate dosages; accurately performs health-monitoring tasks (glucose monitor, blood pressure, weight, etc.) |
| 33. | **Operate tape/CD player/radio/TV** – Accurately locates and selects desired settings on devices |
| 34. | **Grooming** – Accurately shaves; cleans/maintains shaver/razor; combs, brushes, washes hair; applies toothpaste, denture cream; safely clean, trim/file fingernails and toenails |
| 35. | **Eating** – Locates items at place setting and food on plate; seasons food to desired taste; evenly spreads toppings on foods; cuts meats; eats with an acceptable level of neatness |
| 36. | **Locate/organize items in kitchen** – Locates desired items accurately and safely; stores items in a manner that promotes safety and efficient relocation/retrieval |
| 37. | **Dressing** – Able to locate needed items of clothing; identifies clothing colors; matching outfits appropriately |
| 38. | **Avoid collisions/tripping** – Safely ambulates around objects and obstacles in familiar environments |