



Visibility

Vol. 3 Issue 4, 2009

News and Research from the **Envision Low Vision Rehabilitation Center**

Envision 09 Provides Opportunity for Collaboration

*“We are in vision rehab,
and vision rehab by
definition is a multi-
disciplinary approach,” said
Bhavani Iyer, OD, a first-
time attendee of Envision
Conference 09.*

Envision 09, a multi-disciplinary low vision rehabilitation and research conference, was held September 9 - 12 in San Antonio, Texas. Nearly 400 attendees participated, surpassing the attendance and support from

continued on page 10



Medicare Coverage for Low Vision Rehabilitation

Though low vision rehabilitation may not be inexpensive, it is still far more economical and dignified than the alternative. Unfortunately, the obtainable savings by increasing independence for individuals who are blind or low vision isn't clearly recognizable at this point, primarily because there is no national Medicare reimbursement for low vision services.¹⁻²

On April 1, 2006, Congress and CMS (Centers for Medicare & Medicaid Services) began the Medicare Low Vision Demonstration Project, a five-year project established to evaluate the usefulness and utilization of Medicare funding for low vision services.³

Before the project began, Medicare reimbursement for low vision professionals such as low vision therapists, rehabilitation teachers, and orientation

and mobility specialists did not exist. The Medicare Low Vision Demonstration Project allows low vision specialists certified by the Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP) to perform low vision rehabilitation services in clinics and patients' homes under general supervision of a prescribing optometrist or ophthalmologist.⁴ The demonstration is

Medicare Coverage continued on page 2



Medicare Coverage for Low Vision Rehabilitation continued from page 1

limited to services provided in New Hampshire, all five boroughs of New York City, North Carolina, Atlanta, Kansas and Washington.

Unfortunately, some shortfalls of the demonstration do exist. One of the major setbacks experienced by low vision agencies in the demonstration locales is low reimbursement rates. In addition,



Karen Kendrick, OTR/L, CLVT demonstrates a low vision aid at Envision Low Vision Rehabilitation Center.

the Medicare Low Vision Demonstration Project limits services to just nine contact hours over a three-month period.⁵⁻⁶

“Each patient is different,” said Karen Kendrick, OTR/L, CLVT, occupational therapist for the Envision Low Vision Rehabilitation Center. “While I may see one patient for six hours total, another patient may require ten hours or more. It really varies, depending on the patient’s deficits and their individual needs. Low vision rehabilitation is a part of a plan of care, not just an appointment.”

Low reimbursement limits the ability of patients to pay, and limited contact time severely limits possible outcomes, which are necessary for Medicare billing.⁷

For many elderly patients on a limited income, the expenses may prevent them from seeking low vision rehabilitation services. If a patient neglects to seek these vital services, their independence will be forever compromised.

Sadly, the drawbacks of the Medicare Low Vision Demonstration Project – low reimbursement rates, limited contact time, and limited geographic coverage areas – prevent many agencies and low vision service providers from utilizing Medicare billing successfully. Many agencies and providers may opt out of Medicare reimbursement because of the extra costs associated with increased paperwork and the need to hire additional billing specialists.

The demonstration project ends March 31, 2011. If low vision providers show little interest and usage, Congress may not see a reason to expand Medicare coverage nationwide for low vision services.

“We can’t afford the failure of this project,” said Linda K. Merrill, Envision, Inc. CEO. “As a country, we must work together to establish equality and independence for all, including individuals with vision loss.”

For these reasons, several not-for-profit agencies have banded together through the VisionServe Alliance to once again seek legislative remedy of a national Medicare reimbursement policy for low vision rehabilitation by ACVREP professionals.

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Unique Hues, Color Naming and Color Discrimination in a Low Vision Patient with a C203R Gene Mutation

James Nolan, PhD^{1,2} and Shannon Riley, MA,¹
(1. Envision Low Vision Rehabilitation Center, 2. The University of Kansas School of Medicine, Dept. of Ophthalmology)

Compromised color vision is something that many low vision patients encounter as vision loss takes hold, due to decreased cone cells in the retina as a result of numerous retinal degenerative conditions. Genetically, altered color vision can affect many, even those who have standard acuity. Numerous studies report ranges of 6-9 percent of males having altered color vision while approximately 1 percent or less of females show color alterations. In our present study, we are interested in how low vision patients show color naming abilities despite some degree of vision loss and noted discrepancies (or even failure) to pass standard clinical color vision tests.

Berlin and Kay (1969) noted that well-developed languages seem to contain precisely eleven basic color terms. In English, these color terms are red, green, yellow, blue, orange, purple, brown, pink, white, black and gray. Boynton and Olson (1990) suggested that each of these names denotes a different fundamental and unlearned

sensory experience. Crawford (1982) proposed a modification to Berlin and Kay’s definition, which includes four criteria that all basic color terms should meet:

Basic color terms:

1. Occur in the dialects of all informants.
2. Have stability of reference across informants and across occasions of use.
3. Their signification is not included in that of any other color term.
4. Their application is not restricted to a narrow class of objects.

Boynton and Olson (1990) proposed that the link between basic color sensations and their names is congenital and physiologically based.

For our study, the subject (BD) was a 32-year-old male who exemplified 20/160 acuities in both eyes and had been diagnosed with Cone Dysfunction Syndrome. This subject failed all plates in the Ishihara color test as well as other standard color screening tests. Molecular genetic analysis (courtesy of Maureen Neitz, PhD and Jay



James B. Nolan, PhD

“Genetically, altered color vision can affect many, even those who have standard acuity.

Numerous studies report ranges of 6-9 percent of males having altered color vision while approximately 1 percent or less of females show color alterations.”

Neitz, PhD) was performed on BD to determine the type and numbers of the X-linked pigment genes and subsequently, BD was found to possess a C203R gene mutation in a subset of the M genes. We also measured color

naming ability in two color normal control subjects (1 male and 1 female) aged 21 and 35 respectively (M = 28 years), with best corrected acuity of 20/20.

For the purpose of exploring how the phenomenological color world of a subject who possesses a C203R gene mutation matches that of color normal observers, and to assess whether the sensitivity of receptors will influence one's description of color, two variations of a color naming procedure were utilized. In order to examine the experience of color and detect whether the sensitivity of receptors influence subjects description of color, measurements of unique hues were taken based on a stair-step methodology, requiring subjects to choose from stimuli presented on a computer monitor, based on their "best" views of the hues red, blue, yellow and green.

A set of 424 Optical Society of America color chips (Boynton and Olson, 1987) served as stimuli in the color naming experiment for both the subject and controls. Our subject and controls assigned a name for each chip using whatever color term they chose (procedure repeated three times to assess consistency).

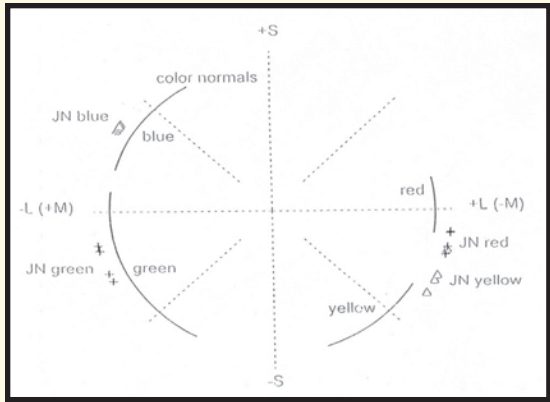
For the color discrimination procedure, the subject and controls (n=2) were tested using a standard pallet of nominal color regions. Procedures were similar to those of previous studies (Berlin and Kay, 1969). Subjects individually viewed the most saturated palette of Munsell colors and reported which region of chips corresponded to 11 basic color terms (white, black, pink, orange, yellow, red, brown, green, blue, purple, and gray). This procedure was carried out for the subject with a C203R mutation under both incandescent and natural lighting conditions.

Our results indicate that despite poor performance on the color discrimination task, BD makes unique hue settings of blue and green that fall within the range of color normal control subjects.

BD shows consistency in naming colors as well as characteristic shifts and confusions. There are

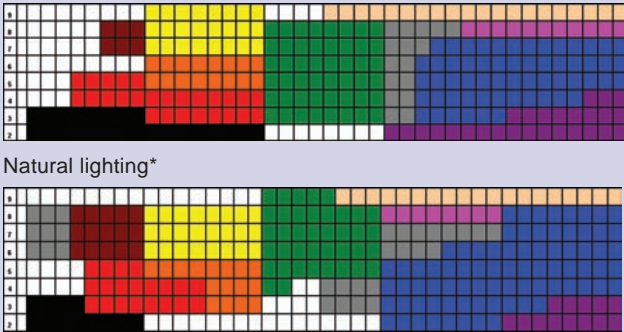
RESULTS

Unique Hue Data for JN and Controls



- Despite poor performance in color discrimination tasks, subject JN makes unique hue settings of blue and green that fall within the range of color normal control subjects.

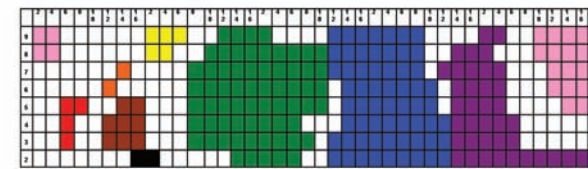
DATA FOR COLOR NAMING UNDER INCANDESCENT AND NATURAL LIGHTING CONDITIONS OF C203R SUBJECT



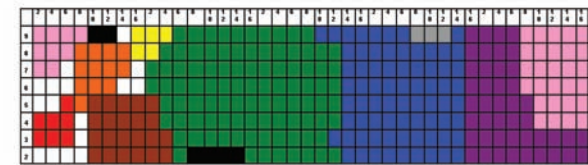
*note: beige colored cells = region for "white".

Gender: M Age: 32
Visual Diagnosis: congenital cone dysfunction syndrome.
C203R M pigment gene mutation.
Known color difficulties: yes Best corrected acuity: 20/160

DATA FOR COLOR NAMING OF CONTROL SUBJECTS



Gender: M Age: 35 Visual diagnosis: none
Known color difficulties: none Best corrected acuity: 20/20



Gender: F Age: 21 Visual diagnosis: none
Known color difficulties: none Best corrected acuity: 20/20

RESULTS (cont'd)

Table 1. Color Naming Consistency

	L	G	J	JN	JN	JN	A	A	R	R
RED	-4	2	-8	pur	red	pur	red	red	pur	pur
GREEN	0	4	2	grn	grn	grn	grn	grn	grn	grn
ORANGE	0	6	-8	org	org	org	org	org	org	org
PURPLE	-3	-3	-1	blu	oin	blu	pin	pin	pur	pin
GRAY	-1	1	-1	gry	pin	pin	gry	wht	brn	brn
PINK	1	1	-5	blu	gry	blu	pin	pin	pin	pin
WHITE	4	2	0	wht	wht	grn	wht	wht	wht	grn
BROWN	-3	3	-3	org	brn	brn	org	brn	brn	brn
YELLOW	3	9	-1	yel	yel	yel	yel	yel	yel	yel
BLUE	-1	-3	3	blu	blu	blu	blu	blu	blu	blu

- Subject JN shows consistency in naming colors as well as characteristic shifts and confusions.

Table 2. 11 Basic Color Terms

Color Term	Subject		
	A	R	J
Green	170	226	340
Blue	147	126	270
Purple	88	96	38
Pink	198	144	63
Orange	74	65	105
Yellow	51	72	101
Brown	34	63	64
Red	29	21	109
Gray	12	15	112
White	45	20	71
Black	0	0	0

- Many light colors were referred to as blue or green while many dark colors were referred to as red or gray by JN.

Table 3. Color Naming Consistency and Inconsistency

CONSISTENT USE					
Color Name	Subject			Total	Percent
	A	R	J		
Green	156	198	147	501	26.2
Blue	136	114	132	382	20
Purple	78	85	9	173	9
Pink	174	116	0	290	15.2
Orange	56	46	42	144	7.5
Yellow	42	58	48	148	7.7
Brown	20	46	3	69	3.6
Red	26	14	86	106	5.5
Gray	8	10	21	39	2
White	36	8	18	62	3.2
Black	0	0	0	0	0
Totals	732	696	486	1914	100

INCONSISTENT USE					
Color Name	Subject			Total	Percent
	A	R	J		
Green	14	26	193	235	22.3
Blue	11	12	138	161	15.3
Purple	10	10	29	49	5
Pink	24	28	63	115	10.9
Orange	18	15	63	100	9.5
Yellow	9	14	53	76	7.2
Brown	14	17	61	92	8.7
Red	3	7	43	53	5
Gray	4	5	91	100	9.5
White	9	12	53	74	7
Black	0	0	0	0	0
Totals	115	152	767	1035	100

- JN shows much less consistent use of color terminology

specific shifts in BD's categories consistent with his color deficiencies (e.g. black for red, enlarged blue, yellow, and green regions, yellow towards green, and blue towards purple). BD's large areas of color categorization under natural lighting conditions are similar to those reported for incandescent data.

Thus, he is able to consistently label the chip colors even when the light falling on the chips (and thus the spectral composition of the light reaching the eye) is dramatically altered. Control subjects' categories were consistent with previous data from color normal subjects. All subjects indicate individual shifts in color space unique to their perceptual color experience. BD shows much less consensus use of color terminology as compared to controls. BD used color terms consistently for 139 out of a possible 424 color chips. In contrast, each control named an average of 260 out of a possible 424 color chips consistently.

These data imply that, despite his inability to pass most color vision tests, BD's color naming ability is remarkably intact. Our unique hue results suggest that BD's settings are within normal ranges for some hues and only slightly out of normal range for others. BD's regions for the 11 basic color terms, while quite large and slightly shifted, were in rough agreement with control subjects'. This calls into question whether standard color vision screening tests do an adequate job of addressing the "perceptual" experience of color in some low vision patients. As the spectral composition of the light reaching the eye is altered, along with the appearance of the chip, BD's color naming ability remains mostly intact and consistent, thus, indicating a remarkable degree of color constancy. Despite the fact that BD shows reduced cone function, he shows consistency in naming colors as well as characteristic shifts and confusions.

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William L. Park, OD, FAAO

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“This case indicates the importance of early referral for low vision rehabilitation, where visual acuity is only a number and does not necessarily correlate with that individual’s quality of life and further areas of life that the individual considers paramount to self worth and well being.”

The Challenges of Multiple Sclerosis and Visual Impairment

Multiple Sclerosis (MS) is a chronic neurological disorder that affects the central nervous system resulting in inflammation and damage to myelin insulation of the nerve fibers and other cells of the nervous system. Impaired nerve signaling may impair normal sensation, movement and thinking. MS typically presents in adults who are 20 to 45 years of age. Occasionally, the disease presents in childhood or late middle age. Twice as many women are affected as men, and persons of Northern European descent appear to be at highest risk for the disease.¹

Visual disturbances include ocular pain, distortion or loss of vision in one eye, diplopia (double vision), impairment of color perception, nystagmus (jerky eye movements), depth perception, decreased ability to see low contrast objects and optic neuritis (inflammation of the optic nerve), which is a common first symptom of MS.²

Approximately 50 percent of people with MS will experience a major depressive episode during the course of their illness, compared to 5 to 15 percent in the general population. Fatigue—which can be an outgrowth of depression or

occur as a primary symptom—frequently compounds depression in persons with MS.³

It has been the author’s experience that MS is a devastating chronic disease, often producing tremendous psychosocial aspects, primarily due to the wax and wane phenomenon of visual performance due to episodes vs. remission.

The psychosocial issues are moreover far more frequent and troublesome (as I have seen throughout my years practicing) if the female is afflicted with the disease, as opposed to the male when it comes to marital status considerations.

This case indicates the importance of early referral for low vision rehabilitation, where visual acuity is only a number and does not necessarily correlate with that individual’s quality of life and further areas of life that the individual considers paramount to self worth and well being.

DC, a 42-year-old African American male from Oklahoma, was originally seen on April 13, 2009 as a result of a referral from his ophthalmologist. The patient was having difficulty with visual acuity and decreased visual performance in his activities of daily living secondary

to manifestations of Multiple Sclerosis (MS).

Chief complaint consisted of the desire to “drive again and to be able to read books to my granddaughter.” The patient reported his vision to be stable at the time of this examination.

Medical history revealed a systemic diagnosis of MS (duration two years) confirmed by an MRI and spinal tap. Treatment had consisted of fusion IV treatments with no history of hospital admissions or exacerbations.

DC reported medium to low energy levels, musculoskeletal weakness (using a cane), dehydration with malaise and loss of function with increased environmental temperature along with escalation of visual problems. Family ocular history was significant for cataracts (uncle) only.

Functional history was significant for difficulty with all reading tasks, financial management, use of a computer and orientation and mobility skills related to vision and systemic implications. There was a history of an increase in falls in the last month (wife voicing this difficulty more than patient).

Social history revealed he lived in a house with his wife and family and was disabled from his job of working in a warehouse due to his MS. He was currently receiving home nursing assistance and physical therapy concerning extremity strength issues. His spouse revealed that he was significantly

more incapacitated than he expressed.

Uncorrected visual acuity was right eye (OD) 20/125⁻¹, left eye (OS) 20/800, both (OU) 20/125⁻¹ (eccentric viewing was with either monocular or binocular fixation). Near-point VA was .25cm/2.5M print habitually with difficulty, complaining of not seeing entire words. Confrontation fields revealed constriction in all quadrants. Contrast sensitivity was profoundly impaired to 1.20 log units.

Extra Ocular Muscles (EOM) were full with poor conjugate gaze, poor EOM skills (saccades, pursuits, tracking) with rotary nystagmus and no presence of a null point. There was no presence of binocularity or stereopsis. DC demonstrated straight upright posture, right hand dominance with good grasp and use of a cane for stability.

Anterior segment evaluation revealed no apparent pathology. Intraocular Pressure (IOP)/Dilated Fundus Exam (DFE) were both deferred due to ophthalmological care six weeks prior to the visit.

Humphrey visual fields demonstrated a generalized temporal arcuate relative field loss in the right eye and absolute to relative field loss throughout the majority of the central field.

A brief telescopic evaluation was performed with a preferred subjective/objective direction to a 3X Design for Vision spiral Galilean telescope

obtaining 20/60 in the distance. Filters elicited a dramatic resolution in light sensitivity and enhancement of contrast, subjectively.

Due to fatigue, the evaluation was terminated. A return visit was scheduled for re-evaluation, assessment by occupational therapy and referral for rehabilitative resources and devices.

DC was seen again two months later for a scheduled consecutive 5-day evaluation. Scheduled objectives were: clinical re-evaluation, D-15 Farnsworth color perceptual testing, micro-perimetry, Goldmann visual field, IOP/DFE, OT referral and possible orientation and mobility training.

Visual acuity and contrast sensitivity findings were the same as the initial visit. Telescopic acuity and the preferred telescopic device to be loaned (OD 3x DVI bioptic) based on clinical assessment were established.

The patient was referred for further evaluation of recommended visual devices, baseline assessment of ADLs with other testing scheduled after occupational therapy assessment and therapy.

Occupational Therapy Karen Kendrick, OTR/L, CLVT

DC was referred to occupational therapy for a low vision evaluation. Upon initial OT assessment, the patient required maximum assistance with read-



ing mail, the newspaper, and magazines. He could read labels and price tags with minimal assistance, but was unable to read menus in restaurants at all. He was also unable to manage his medications and was dependent on his spouse to read and dispense the medications to him.

This patient required moderate assistance when it came to setting appliance dials on the washer/dryer as well as microwave. He required minimal assistance with writing. DC was also very light sensitive both indoors and outdoors.

Because DC was from Oklahoma, the patient made arrangements to stay in Wichita for a week and was seen by the occupational therapist on a daily basis.

Filters were assessed for his light sensitivity and he found light plum to be beneficial

for indoors and dark plum to provide best comfort for outdoors. This patient was loaned the filters for the week that he was receiving training and was reluctant to return the loaners due to the increased comfort he experienced throughout the week.

Magnification devices were also assessed. The closed circuit television (CCTV) was found to be the most beneficial for reading. DC was able to place a children's book under the CCTV and was able to read a book, while at the same time his granddaughter could view pictures on the monitor. After demonstrating the ability to read with the CCTV, DC exclaimed, "I haven't been able to read in so long!" This patient also practiced writing using the CCTV and was able to write

his name, address and shopping list independently utilizing the CCTV and a 20/20 pen.

DC was also assessed for a hand magnifier to increase portability. He demonstrated the capability to read price tags, labels, and children's books independently using a 5x lighted stand magnifier.

DC and his spouse were also instructed in Independence Boulevard on how to tactually mark appliances with bump dots and how to modify his environment utilizing contrast manipulation (i.e. dark towels against white wall to allow him to locate them easier). Independence Boulevard is a simulated environment within Envision Low Vision Rehabilitation Center that includes a grocery store, restaurant, and fully functional apartment with kitchen,

bedroom, laundry room, and living room.

Due to financial hardship, a letter was written to the Oklahoma Multiple Sclerosis Foundation to request funding for a CCTV and plum filters, which were the two devices that this patient felt would be of greatest benefit.

At discharge from occupational therapy at the end of the week, DC was able read the newspaper, a children's book and a magazine with modified independence utilizing the CCTV. He reported decreased glare both indoor and outdoor with use of light plum and dark plum filters. He was also able to spot-read labels and medication bottles with modified independence using either the CCTV or 5x illuminated stand magnifier. Resources recommended for this patient included free directory assistance and talking books. The patient was given the applications to receive these free services.

Orientation and Mobility Tyler Hamilton, MA, COMS

Patient initially refused O&M services. After reiterating the need for the patient to be able to function more independently, he agreed. An O&M assessment was completed and the O&M specialist found the patient to be using his support cane to scan the environment in unfamiliar places. He was issued a 50" white cane with an Ambu Tech roller tip. He was shown

basic cane skills and protective techniques.

Due to family illness, the patient and his family were called to return home to Oklahoma, prematurely ending scheduled rehabilitation efforts. Unfortunately, he was not able to complete all his training.

Sensory Evoked Potential Testing

Evoked potentials (visual, brainstem auditory, and somatosensory) may be useful in demonstrating the presence of subclinical lesions in sensory pathways or in providing objective evidence of lesions suspected on the basis of subjective complaints. Of the sensory evoked potential tests, the visual evoked potential is the most useful because it can provide objective evidence of an optic nerve lesion that may not be evident on an MRI scan. The patient was referred to Northeastern State University, Oklahoma College of Optometry for a baseline electro-diagnostic Visual Evoked Potential.⁴

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- 2 Visual Impairment in MS. *MS Matters*, UK Multiple Sclerosis Society June 2008. http://www.msif.org/en/about_ms/ms_by_topic/visual_problems/ms_society_articles/visual_impairmen.html.
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William L. Park, OD, FAAO is in private practice in Wichita, KS. Dr. Park is committed to outreach efforts in stemming the epidemic of diabetes. He works exclusively with patients referred for low vision evaluation, low vision rehabilitation and neurological vision loss. He is a past Director of Low Vision Services, Lions Research & Rehabilitation Center, Wilmer Eye Institute-Johns Hopkins University. Dr. Park can be reached at William L. Park, OD, LLC, www.parklowvision.com, 610 N. Main, Suite 201 Wichita, KS 67203, (316) 440-1690 or drpark@parklowvision.com.

Karen Kendrick, OTR/L, CLVT is a practicing occupational therapist and certified low vision therapist at Envision Low Vision Rehabilitation Center, practicing out-patient low vision therapy with emphasis in neuro-visual deficits.

Tyler C. Hamilton, COMS, is a Certified Orientation and Mobility Specialist with the Envision Low Vision Rehabilitation Center. Tyler has a BS in Psychology from Stephen F. Austin State University, a BA in Sociology from the University of Arkansas Little Rock, and a Masters in Rehabilitation for the Blind from the University of Arkansas Little Rock. Tyler is certified by the Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP).

the previous year.

"We know conferences are struggling with decreased numbers because of the economy," said Linda K. Merrill, CEO. "But, I am thrilled to report that we actually surpassed last year's registration numbers, proving what we already know – low vision professionals around the world care tremendously about the best practices of patient care and the field of low vision rehabilitation."

The mission of the Envision Conference is to improve the quality of low vision care through excellence in professional collaboration, advocacy, research and education. The focus of Envision 09 was **"Excellence through Collaboration."** This mission and focus was illustrated through several educational sessions, as well as the "Excellence through Collaboration" Symposium and the Mission Keynote.

With 48 clinical education sessions, 10 research sessions, and eight workshops, Envision 09 provided 111 hours of low vision rehabilitation and research education. Those certified through professional organizations were able to collect 29 hours of continuing education.

Envision 09 also saw an increase in the number of exhibitors this year. Attendees had the opportunity to visit with vendors from 24 low vision companies.

"If you are in low vision, you definitely have to be at the Envision Conference," said Jim Keriotis, Sales, Nidek, Inc.

In addition to educational sessions, workshops and exhibits, attendees were able to enjoy

several network- **David Lewerenz, OD, FAAO, speaker at Envision 09, works with participants during a workshop.**

ing opportunities including an opening night welcome reception, numerous coffee breaks and a lunch buffet.

"The conversations I am having outside of the lectures and outside of the main speaking halls have been the most beneficial for me," said Michael Crossland, OD, PhD, a speaker at Envision 09.

Planning for Envision 2010 is underway and online registra-

tion and submissions will be open soon. Envision 2010 will be held September 22 - 25, once again in San Antonio. The focus of the 2010 conference will be **"Excellence in Advocacy."**

Please contact Michael Epp, Director, Outreach & Continuing Education with questions about the Envision Conference at michael.epp@envisionus.com.



Important dates to remember:

- **December 1, 2009** - Online registration and Submissions Open
- **March 29, 2010** - Deadline for Clinical Education and Research Submissions
- **April 30, 2010** - Clinical Education and Research Presentation Selection Notification
- **July 9, 2010** - Deadline for Early Bird Registration
- **July 16, 2010** - Deadline for Advance Price Exhibitor Registration



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Save the Date

September 22-25, 2010

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December 1, 2009

Online Registration
and Submissions Open

March 29, 2010

Deadline for Clinical
Education and Research
Submissions and Edits

April 30, 2010

Clinical Education and
Research Presentation
Selection Notification

July 9, 2010

Deadline for Early
Bird Registration

Deadline for Presentation
Media and Handouts

July 16, 2010

Deadline for Advance
Price Exhibitor Registration

August 16, 2010

Cancellation Deadline

www.envisionconference.org

About Envision Low Vision Rehabilitation

The Envision Low Vision Rehabilitation Center provides comprehensive, multi-disciplinary low vision rehabilitation and services for people with vision loss. The center's goal is to help patients maximize their independence and realize their best functional vision. The center achieves this by offering a comprehensive low vision rehabilitation program unique to the needs of each patient. Envision provides low vision rehabilitation regardless of ability to pay. Call to find out about the availability of financial, medical assistance.

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