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VIEW POINT

Advancing low vision services: A plan for Australian optometry

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Every optometrist in Australia has been trained to provide primary low vision services; however, many do not. Now is the time to change this. The Optometrists Association Australia Low Vision Working Group presents a plan to advance the provision of low vision services by optometrists. The plan comprises four main priority areas for action: 1. developing evidence-based policy, 2. supporting low vision education, 3. engaging with key stakeholders and 4. improving remuneration. It is the view of the Working Group that no patient with low vision should be left without support and that all optometrists, together with all eye-care practitioners and providers, have a central role in advancing the provision of low vision service in Australia.

ADVANCING LOW VISION SERVICES: A PLAN FOR AUSTRALIAN OPTOMETRY

Based on the most recent data available (from population studies conducted some two decades ago), there are an estimated 180,000 or more Australians who have low vision (uncorrectable visual acuity worse than 6/12 in the better eye), 50,000 of whom are legally blind.[1] While important new treatments for 'wet' macular degeneration have been developed since, their actual impact on the prevalence of low vision and legal blindness is yet to be determined. Regardless, there remain other significant causes of low vision, such as diabetic retinopathy and glaucoma. The majority of people with low vision retain some useful sight. Low vision rehabilitation and optical devices can help to maximise the remaining sight and improve quality of life. Indeed, the effectiveness of low vision rehabilitation has been demonstrated in several clinical trials;[2,3] however, in spite of many benefits, utilisation rates are alarmingly low. Just 20 per cent of Australians with low vision receive low vision rehabilitation services,[1,4] even though it has been suggested that more than 90 per cent could benefit.[5]

Every optometrist in Australia has been trained to provide low vision assessment and rehabilitation. However, few optometrists deliver low vision services in private practice[6] and the number working with low vision organisations as part of a multidisciplinary team has declined in some jurisdictions. Furthermore, the number of claims for Medicare item 10942 for optometric low vision assessment has been declining, from 5,033 after its introduction in 2004 to 3,938 in 2012 (www.medicareaustralia.gov.au/statistics/mbs_item.shtml), in spite of a substantial increase in the population aged 65 years and over (from 2.7 million in 2006 to 3.1 million in 2011, www.abs.gov.au).

Now is the time to change this. Due to increasing longevity, the proportion of the population aged 65 years and over is projected to increase from 13 per cent in 2007 to between 23 and 25 per cent in 2056.[7] Similarly, the proportion aged 85 years and over is projected to increase from 1.6 per cent in 2007 to between 4.9 and 7.3 per cent in 2056.[7] Given that the main causes are strongly age-related, vision impairment is expected to increase dramatically in the coming years.[1] Many of those affected will be among the oldest and unable to travel long distances for services. Compared with other eye-care providers, optometrists are well distributed geographically, including in regional and remote areas of Australia.[8] Therefore, optometrists are well placed to provide reasonably accessible low vision services, whether it is in private practice, working with nearby teams from low vision organisations or as part of a visiting service.

So, what are the reasons that optometrists do not commonly provide low vision services and what can we do to address the problem? In 2011, Optometrists Association Australia (OAA) convened an expert Low Vision Working Group (LVWG) to determine answers to these questions, to promote the provision of low vision services by optometrists and to advise the OAA National Board on issues related to low vision (Table 1).

Membership of the low vision working group was by invitation from the OAA Board. At present, there are 20 members, with representation from each state. The Working Group comprises optometrists who are expert low vision clinicians, academics, educators and researchers, from private and

Mission of Optometrists Association Australia (OAA)
Low Vision Working Group
Provide a forum for Optometrists Association Australia members to collaborate in developing low vision policy.
Identify and examine barriers to greater low vision involvement and offer solutions to these problems.
Provide expert advice to Optometrists Association Australia in its assessment of the provision of low vision services by optometrists, including billing issues.
Assist in the development of resources to stimulate and support optometrists to work in this area of practice.
Guide the Optometrists Association Australia in becoming more actively engaged with key low vision service provider groups.

Table 1. The mission of the Optometrists Association Australia (OAA) Low Vision Working Group, established by the OAA National Board in 2011

public clinics and from non-government organisations for the vision impaired. A full list of past and present members is provided in the acknowledgements. The first meeting was held in September 2011 and quarterly thereafter. Here we present the specific goals of the group, our views on current barriers to the provision of low vision services and a plan to advance the provision of these services by optometrists.

IDENTIFYING BARRIERS TO PROVISION OF LOW VISION SERVICES BY OPTOMETRISTS

At the first meeting members brainstormed ideas on the goals that would advance low vision service delivery and the current barriers to optometrists providing low vision services in Australia. Ideas included those derived from a preliminary review of Australian studies on barriers.[6,9–11] A nominal group technique was used to ensure that all members contributed. The meeting was held via teleconference and those who could not attend were asked to contribute via email. Ideas were collated by the convenor and listed in random order using an electronic random number generator. Two lists were constructed, one of group goals and one of barriers, which were circulated to all members via email. Members were asked to rank the importance of each idea on a scale from 1 to 5 (where 1 = very low, 2 = low, 3 = moderate, 4 = high, 5 = very high).

Fourteen goals were generated and are presented in order of mean importance in Table 2. As expected, the majority (10 of 14) of goals were of moderate to very high importance. The top six priorities for the Working Group were to:

1. promote that optometrists should take the lead role in providing low vision care
2. debunk the idea that nothing can be done for low vision
3. improve the referral process to low vision services
4. promote the importance of optometric low vision services to the public, the optometry profession, other health care professions and low vision organisations
5. increase student confidence and exposure to low vision practice and
6. seek ways of increasing remuneration for optometrists providing low vision services.

With respect to barriers, a total of 37 were identified. To address the issues and facilitate the development of solutions, individual barriers were sorted and grouped into themes by the convenor using the inductive approach of Grounded Theory (with systematic, iterative thematic coding of data, synthesis and integration).[12] This was presented to the group, discussed and revised until consensus was reached. The resulting themes and individual barriers are shown in Table 3. Of the top eight barriers perceived to be highly important by the Working Group, three were related to declining referrals for low vision services, followed by:

1. low vision care in early stages not being viewed as basic optometry and should be
2. lack of awareness of ophthalmologists about what optometrists can do
3. optometrists providing low vision care not being adequately remunerated for their skills and time
4. lack of recognition that optometrists provide excellent low vision services and have a central role as case managers and
5. lack of a professional peer support and mentoring group in low vision optometry.

IDENTIFYING SOLUTIONS TO INCREASE THE PROVISION OF LOW VISION SERVICES BY OPTOMETRISTS

At the second meeting, using the nominal group technique, members brainstormed ideas on solutions to barriers and increasing the involvement of optometrists in providing low vision services, including those obtained from a preliminary review of Australian studies and literature.[6,9–11,13] As before, ideas were collated by the convenor and listed in random order. Members were asked to rank the importance of each solution on a scale from 1 to 5 (where 1 = very low, 2 = low, 3 = moderate, 4 = high, 5 = very high), rank the feasibility of achieving each solution on a scale from 1 to 3 (where 1 = difficult, 2 = moderate, 3 = easy) and nominate when each solution should be achieved (never, in the short-term, medium-term or long-term).

Eighteen solutions were generated and are presented in order of mean importance in Table 4. As expected, the majority of solutions (17 of 18) were, on average, ranked moderately to very highly important. Of greatest importance was liaising with and engaging organisations for the vision impaired. Other highly ranked solutions were educating ophthalmologists and general practitioners by developing better referral systems and communication, adapting the SmartSight model[14] for Australia and educating students by including more clinical experience. There was a mix of short, medium

Goals	Importance† Mean ± SD
1. Promote that optometrists should take the lead role in providing low vision care	4.46 ± 0.66
2. Debunk the idea that nothing can be done for low vision	4.31 ± 0.86
3. Improve the referral process to low vision services	4.31 ± 0.75
4. Promote the importance of optometric low vision services to the public, the optometry profession, other health care professions and low vision organisations	4.23 ± 0.83
5. Increase student confidence with and exposure to low vision practice	4.23 ± 0.93
6. Seek ways of increasing remuneration for optometrists providing low vision services	4.23 ± 0.93
7. Enhance the knowledge optometrists and other health care professionals have about available low vision services	4.15 ± 0.69
8. Develop ongoing support and education in low vision care within the profession of optometry	4.15 ± 0.80
9. Improve communication between optometrists involved in low vision care and other key professionals, including ophthalmologists	4.08 ± 0.76
10. Inspire recent optometry graduates to get involved in low vision care	4.00 ± 0.71
11. Inform the public about the low vision services that are available	3.77 ± 1.42
12. Increase public access to low vision services	3.46 ± 0.98
13. Share ideas to advance low vision service delivery in developing countries	3.46 ± 1.20
14. Increase low vision service provision in aged care facilities	3.08 ± 0.76

† Importance ranked on scale from 1 to 5 (where 1 = very low, 2 = low, 3 = moderate, 4 = high, 5 = very high).

Table 2. Prioritisation of goals for advancing the delivery of low vision services

and long-term solutions. Some solutions were inter-related and several could be achieved by one intervention.

THE AUSTRALIAN LOW VISION PLAN

From the solutions generated, four main areas were identified for advancing the involvement of optometrists in low vision service delivery:

1. gathering evidence and developing policy
2. supporting low vision education
3. seeking engagement with key stakeholders and
4. improving remuneration.

A conceptual framework of these key areas for action, how they might be developed and delivered, and to which groups the outcomes might be disseminated was generated, discussed and revised by the group until consensus was reached (Table 5).

DISCUSSION

The OAA Working Group has developed a framework and plan for advancing the delivery of low vision services by optometrists in Australia. A multidimensional approach to the issue is recommended, involving action in the areas of evidence-based policy development, low vision education, key stakeholder engagement and remuneration.

First, we recommend and undertake to develop policies that are underpinned with evidence. A useful starting point would be a census of all low vision service providers, device manufacturers, support groups and educators in Australia to map services and resources. With the introduction of the new National Disability Insurance Scheme,[15] this information will be of particular value not only to policy makers and planners in optometry but to government, managers of low vision service providers and consumers. In addition, evidence on policies and models of care that have been effective in other countries should be gathered systematically to inform the development of policies suitable for Australia. For example, the American Academy of Ophthalmology guidelines and accompanying SmartSight model have been useful in the USA and Canada and because it was developed by ophthalmologists, may encourage greater involvement by local Australian ophthalmologists, as well as optometrists.[14,16] The SmartSight model functions to ensure that all patients are offered the type of evaluation and rehabilitation recommended in the American Academy of Ophthalmology guidelines. Four main levels of service delivery are suggested. Level one asks all practitioners examining low vision patients to 'Recognise' and 'Respond', by assuring the patient that much can be done to improve their function, providing an information sheet and referring for services. Level two asks eye-care practitioners to provide basic assistance to the many patients with mild to moderate low vision who require simple interventions. They should: 'record' visual function; 'refract'; 'prescribe'; appropriate spectacle additions, low-power magnifiers, lighting and glare filters and 'report' to primary care physicians. Level three is a guide for practitioners interested in providing more comprehensive low vision evaluation and rehabilitation services, including high-power magnification devices. Level four is a guide to providing assistance to patients who require full evaluation and rehabilitation services, which comprises level three evaluation and services, as well as training in activities of daily living, training in orientation and mobility and provision of counselling by a team of multidisciplinary professionals. Regardless of the particular policies and model developed for the Australian context, consistent messages should be the need to:

1. debunk the mistaken idea that, "Nothing more can be done"

Referrals (3.61)	Attitude of optometrists (3.55)	Attitude of ophthalmologists (3.33)	Remuneration (3.96)	Lack of recognition of low vision optometrists (3.78)	Education, ongoing learning and support (3.63)	Lack of public awareness (3.19)	Co-ordination of care (3.02)	Impact of new treatments (3.54)	Patient psychological stage of adjustment (3.23)
Fewer referrals from ophthalmologists (4.38 ± 0.87)	Low vision care in early stages is not viewed as basic optometry and should be (4.15 ± 0.90)	Lack of awareness of ophthalmologists about what optometrists can do (4.15 ± 0.80)	Optometrists providing low vision care are not adequately remunerated for their skills and time (4.08 ± 0.76)	Lack of recognition that optometrists provide excellent low vision services and have a central role as case managers (4.00 ± 0.91)	Lack of a professional peer support and mentoring group in low vision optometry (4.00 ± 1.00)	Lack of public awareness about the low vision services that are available (3.54 ± 1.27)	Loss to follow-up after referral to ophthalmology (3.54 ± 1.13)	Impact of new treatments for low vision conditions, in particular macular degeneration (3.54 ± 1.20)	The patient's psychological stage of adjustment to low vision (3.23 ± 0.93)
Lack of referrals from other optometrists (4.31 ± 0.75)	Lack of optometrist involvement in low vision care (3.77 ± 0.83)	Ophthalmologists view it as failure to have to refer patients to low vision services (3.31 ± 1.25)	Low health fund rebates for low vision devices (3.85 ± 1.21)	Lack of recognition of low vision as a specialty (3.92 ± 1.12)	Lack of student optometrist experience in low vision clinics (3.54 ± 1.27)	Lack of public and practitioner awareness of health fund rebates for low vision devices (2.85 ± 1.21)	Lack of co-ordinated low vision care (3.00 ± 0.91)		
Declining overall referrals for low vision services (4.23 ± 0.60)	Lack of enthusiasm by students and recent optometry graduates (3.77 ± 0.83)	Ophthalmologists are not interested in providing low vision care themselves (3.08 ± 1.44)		Declining involvement of optometrists in providing low vision services at some low vision organisations (e. g. Vision Australia) (3.77 ± 0.83)	Lack of inspiration and mentoring for students, recent graduates and optometrists wanting to get involved in low vision care (3.54 ± 1.20)		Hospital-based services are a low priority in Victoria (2.85 ± 0.56)		
Referrals are too late with respect to level of vision loss (3.69 ± 1.38)	The need for additional equipment and devices in practice (3.46 ± 0.78)	Ophthalmologists not wanting to give patients conflicting messages ± if they refer patients to low vision services, the patients may erroneously perceive that they will not get ongoing support from their ophthalmologist (2.77 ± 1.09)		Low vision agencies view optometrists as interchangeable with and more expensive than orthoptists (3.62 ± 0.87)	Optometrists lack confidence because of infrequent opportunity to practise low vision care (3.46 ± 0.97)		Services not being co-located (2.69 ± 0.75)		
Lack of referrals from GPs (3.62 ± 1.12)	Lack of utilisation of Medicare item 10942 (3.15 ± 0.99)			Lack of / declining engagement with non-for-profit low vision organisations (3.62 ± 0.96)					
Poor referral letters (2.54 ± 1.20)	Negative attitude and low motivation of optometrists themselves (3.15 ± 0.99)								
Poor report letters (2.54 ± 1.20)	Lack of involvement of corporate optometry (3.08 ± 0.86)								

Table 3. Perceived barriers to low vision service provision, grouped by theme (mean importance and SD in parenthesis)

Solutions	Importance† (mean ± SD)	Feasibility§	Timeframe for achievement¶
1. Liaise with and engage non-government organisations for the vision impaired	4.33 ± 0.72	Moderate	Medium
2. Educate ophthalmologists and general practitioners by developing better referral systems and communication	4.20 ± 0.68	Moderate	Medium
3. Adapt the SmartSight model for Australia (including promoting that optometrists should take the lead role in providing low vision care; debunking the idea that 'nothing can be done' for low vision)	4.13 ± 0.92	Moderate	Short
4. Educate students by including more clinical experience	4.13 ± 0.92	Moderate	Medium
5. A low vision page on the OAA website (including directory and information for professionals and the public)	4.07 ± 0.80	Easy	Short
6. Seek higher rebates for low vision devices from health benefits funds	4.07 ± 1.03	Moderate	Short
7. Educate the optometry profession through continuing professional development seminars, workshops and conference presentations (face-to-face and online)	4.00 ± 1.25	Moderate	Short
8. Conduct a census and analysis of low vision rehabilitation services provided on a state-by-state basis, (including types of services offered, involvement of optometrists, relationships between optometry and key stakeholders, future plans for service delivery, undergraduate and postgraduate education, continuing professional education)	3.85 ± 0.56	Moderate	Medium
9. Develop referral and report templates for optometrists, ophthalmologists, general practitioners and health care providers	3.80 ± 0.86	Easy	Short
10. Seek higher remuneration for optometric low vision services	3.73 ± 0.80	Difficult	Long
11. Conduct a public awareness campaign	3.60 ± 0.74	Moderate	Long
12. Review and summarise the literature on barriers to optometrists providing low vision services in Australia	3.47 ± 0.92	Moderate	Medium
13. Seek industry support	3.47 ± 0.99	Moderate	Medium
14. Educate the optometry profession by developing a credentialing course for those wanting to provide comprehensive low vision services	3.40 ± 1.06	Moderate	Long
15. Establish a Low Vision Society / Community of Practice	3.33 ± 1.05	Easy	Medium
16. Review and summarise the literature on low vision service models and solutions that could be applied in Australia	3.08 ± 0.95	Moderate	Medium
17. Publish group goals and outputs	3.07 ± 1.03	Moderate	Short
18. Broaden the scope of low vision to include aged and disability care	2.67 ± 1.23	Moderate	Long

† Importance ranked on scale from 1 to 5 (where 1 = very low, 2 = low, 3 = moderate, 4 = high, 5 = very high).
§ Feasibility of each solution ranked as difficult, moderate or easy to achieve. The response most often chosen (mode) is presented.
¶ Members nominated when each solution should be achieved (never, in the short-term, medium-term or long-term). The response most often given (mode) is presented.

Table 4. Prioritisation of solutions for advancing low vision service delivery by optometrists

2. have optometrists take a lead role in ensuring that something is done for every patient with low vision (by at least providing Level one and two care and referring to low vision organizations, where required);
3. improve referral pathways and communication between optometrists, ophthalmologists, general practitioners and low vision service organisation.

We also recommend supporting pre- and post-registration education in low vision rehabilitation. In particular, optometrists in training should be provided with sufficient clinical learning opportunities to increase confidence in providing low vision services independently upon registration. For practising optometrists, there should be greater opportunities for continuing professional development related to low vision. Low vision rehabilitation should be part of every local educational optometric conference. For optometrists who wish to provide comprehensive low vision services, we suggest a national program of accreditation would be favourable. Again, this may become important with regard to the new National Disability Insurance Scheme. In addition, the establishment of an interprofessional Australian Low Vision Society could provide encouragement and mentoring for those with a special interest in low vision rehabilitation. It could also provide ongoing direction to further advance the field.

We have the view that it is essential to further develop strong working relationships with key stakeholders of low vision services. At this time, those identified as priorities are low vision organisations providing services to both adults and children (including orthoptists, occupational

Key action areas to develop . . .	How . . .	Groups to target . . .
I. Evidence and policy	Publication in the scientific literature	Optometrists
• OAA LVWG plan		Ophthalmologists
• Systematic review of barriers		General practitioners
• Systematic review of solutions and models of care		Low vision organisations
• Develop OAA policy based on the SmartSight model (and review of others)	Website	Optometrists
• Including promoting optometrists taking lead role debunking the idea 'nothing can be done' for low vision ± improving referrals		Ophthalmologists
• Mapping of current Australian low vision rehabilitation services and resources		General practitioners
		Low vision organisations
		Public
	CPD workshop road show	Optometrists
		Ophthalmologists
		General practitioners
		Low vision organisations
	Booklet/ phone app	Optometrists
		Ophthalmologists
		General practitioners
		Low vision organisations
II. Low vision education	Continuing professional development at local conferences	Optometrists
		Low vision organisations
	Continuing professional development workshop road show and / or webinar	Optometrists
		Low vision organisations
	• Policy	
	• Practice: Case-based learning	
	• Referral	
	University and post-graduate education	Schools of optometry
	• Undergraduate students	Optometrists
	• Accreditation for comprehensive practice	• Practising and students
	Community of practice / Low Vision Society	Optometrists
	• Directory	• Practising and students
	• Mini-symposium; annual dinner	Ophthalmologists
		Low vision professionals and researchers
III. Key stakeholder engagement	Meetings	Low vision organisations (adult and children)
	Provide input on main issues	
	Provide input on developments	Advocacy groups (Vision 2020 and state Vision Initiatives)
	Funding support	
		Ophthalmologists
		Support groups
		Industry
		Health funds
		Medicare
		Schools of optometry
IV. Remuneration (engage key stakeholders to assist)	Increase benefits for low vision devices	Health funds
	Increase benefits for low vision services	Government / Medicare
	Include referral from ophthalmologists in item 10905	

Table 5. The Australian Low Vision Plan. A conceptual framework of key actions to advance the provision of low vision services by optometrists.

therapists, orientation and mobility professionals, counsellors, welfare workers, educators and managers employed by these organisations), advocacy groups and initiatives (through Vision 2020), ophthalmologists, support groups, industry, health funds, Medicare and schools of optometry.

Finally, costs are a significant barrier to provision and uptake of services. We should advocate for increased remuneration for practitioner services and increased reimbursement for low vision devices.

Through this plan, the Optometrists Association Australia Low Vision Working Group will strive to expand optometric low vision services and improve access to quality care for increasing numbers of Australians with low vision, including those from low income and marginalised groups. We believe that no patient with low vision should be left without support and that all optometrists, together with all eye care practitioners and providers, have a central role in advancing the provision of low vision services in Australia. Let us leave no low vision patient in the community without support.

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It should be noted that the ideas and plan proposed represent the views of the Optometrists Association Australia Low Vision Working Group and not necessarily the views of others. There are very likely alternate perceptions and viewpoints. The members of the Low Vision Working Group wish to acknowledge Optometrists Association Australia for having the foresight to convene this group and promote the delivery of low vision services by optometrists, so that all people with visual impairment might benefit.

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