VISION

Designated Service Coordinator Training

Supporting Families who have children who are deaf, hard of hearing, visually impaired, blind or deaf-blind

Terminology

A

Developmental Therapist Vision

is NOT a

Vision Therapist

- DTV – Educator
- VT – Medical Clinician

EI does not pay for **Vision Therapy**

1. A Developmental Therapist Vision is NOT a Vision Therapist.
2. A DTV is an educator and works with children to help them learn in spite of their identified visual impairments;

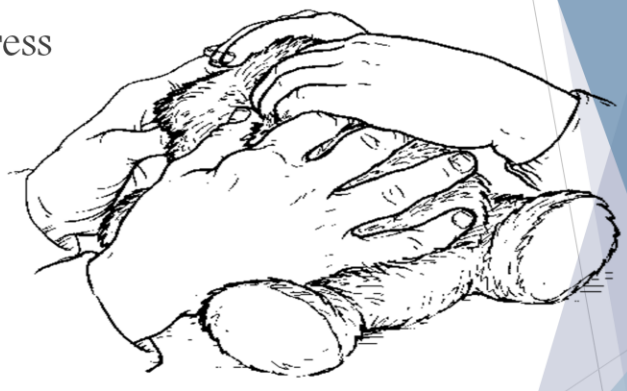
while a VT is a medical clinician who uses specialized eye exercises and experiences to help individuals (who typically have normal acuity and field) to use their vision effectively or improve their use of vision.

It is very important that you understand the difference between these two practices and promote the use of appropriate terminology. Doctors do not respond positively when parents come to their eye appointment and report that early intervention is requesting their child have vision therapy services. Vision Therapy is a medically prescribed and administered service.

4. EI does not pay for vision therapy. Please use the article entitled "DTVs are not Vision Therapists" in your handouts to help educate the parents, service coordinators and/or doctors in your region.

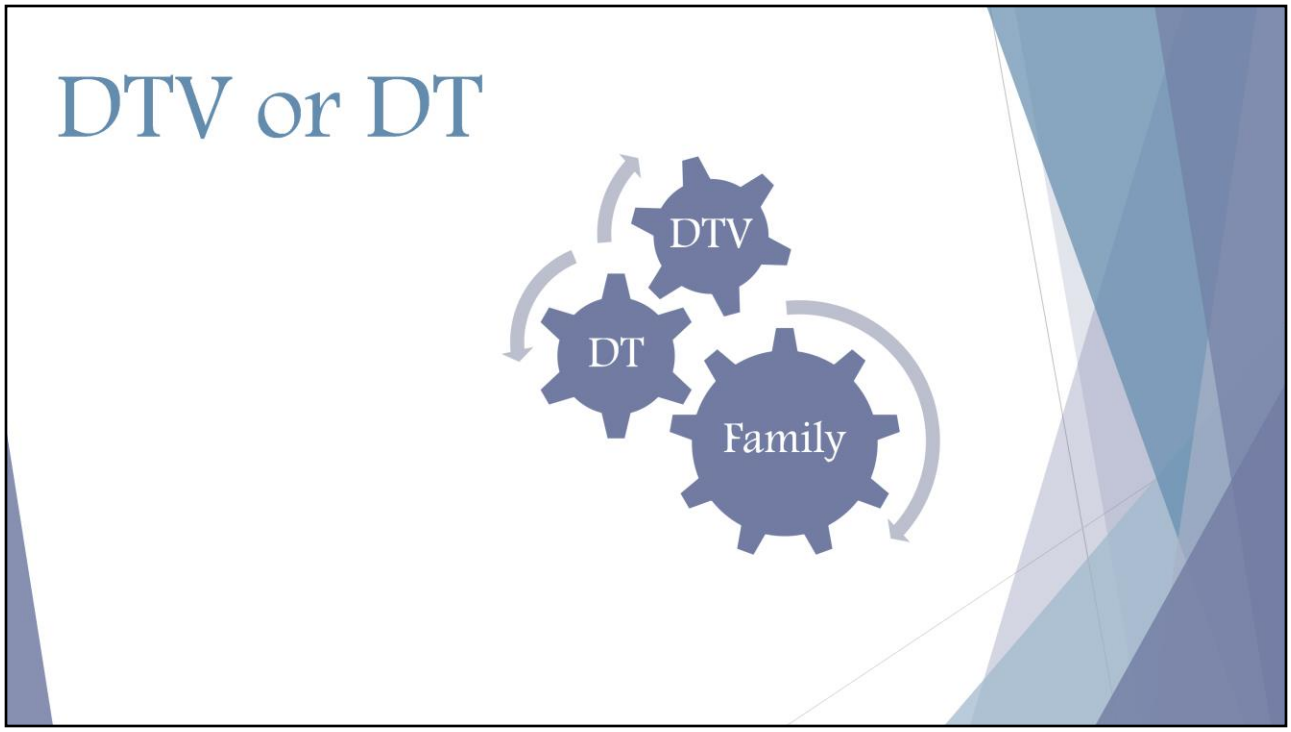
DTV Services

- Developmental Progress
- Literacy
- Network
- Resources
- Technology
- Educational Options
- Dream of the FUTURE



A DTV can help families address the many developmental delays that often accompany vision loss. Typical areas of concern include cognitive understanding, literacy, and motor development. In addition, DTVs can help families locate helpful resources and technology.

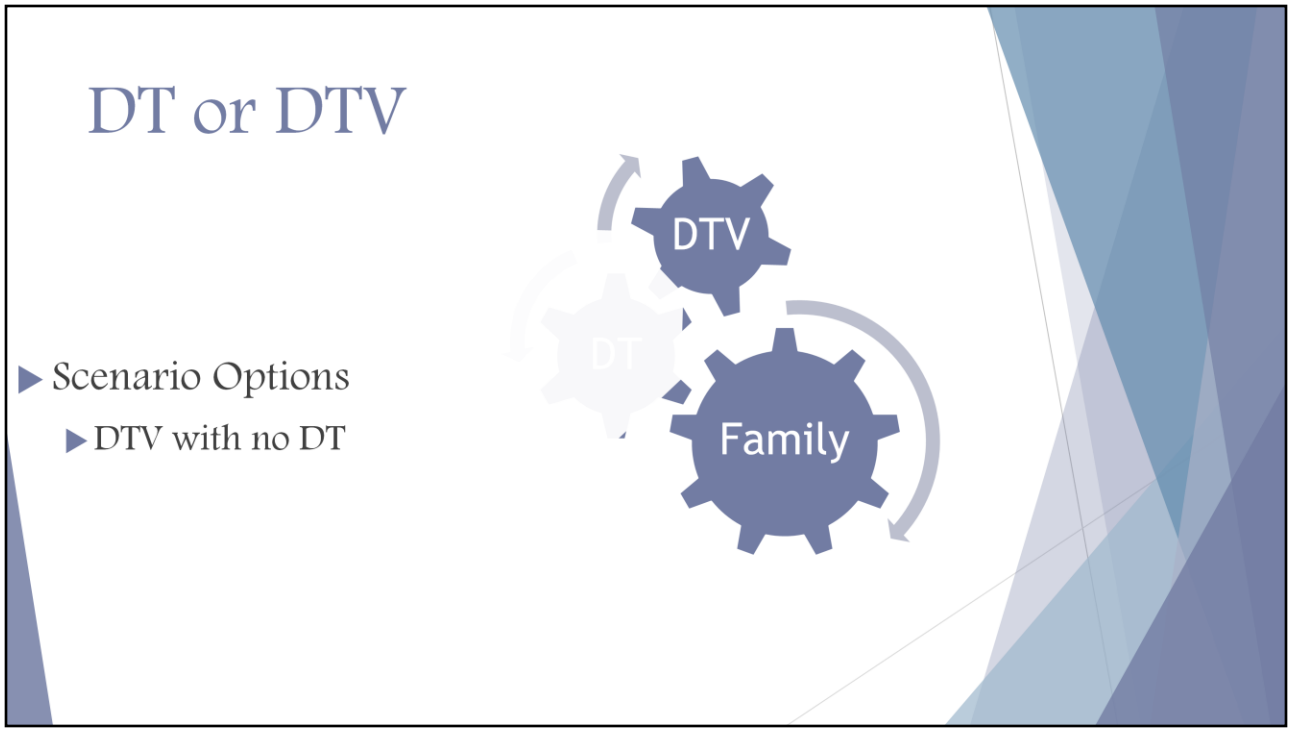
Children with vision loss can attain much, but they need to be taught some essential skills to reach their potential. For example, reading is possible, but children with vision loss must accomplish the task in a different way than their sighted peers. Parents need the resources (such as Braille books) and education (such as learning the Braille code) to help them lead their children down a path that can end in success.



At this point you may have come to the conclusion that you need either a DT or a DTV for a family, but never both. That is not a true statement. Let's explore this thought a little.

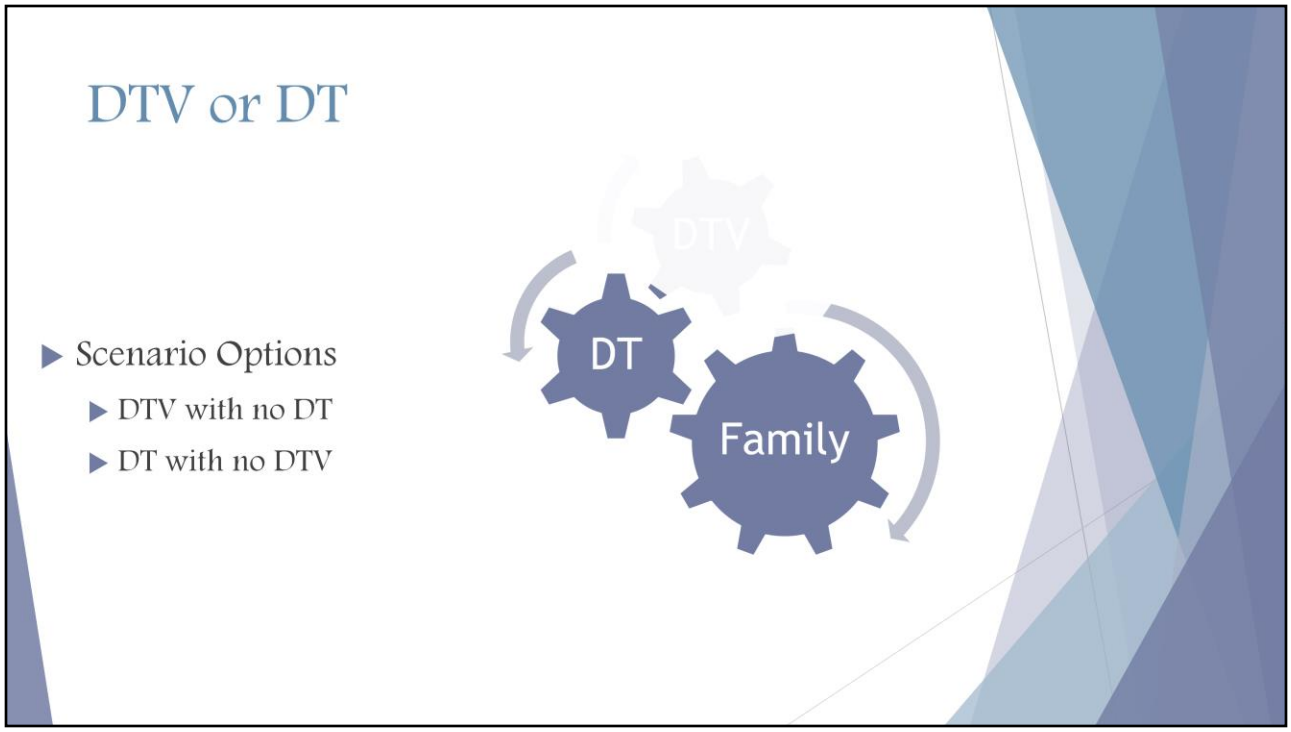
Should I use a DTV or a DT for a given child?

If a child has a diagnosed visual impairment a DTV Evaluation should always be a service that is offered to a family. The question then, is whether to use the DTV in conjunction with a DT or not. I will offer general scenarios for using the services together and separately.



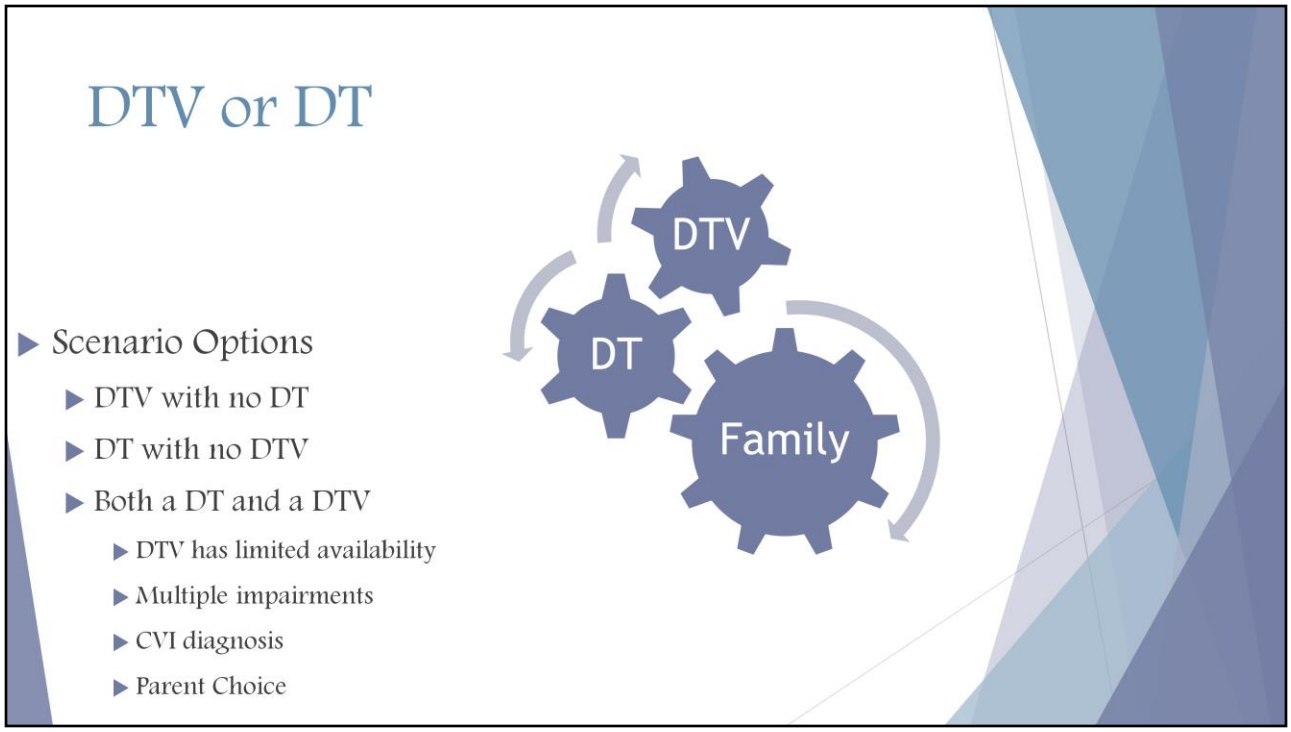
1. **DTV with no DT**
Vision is the only or primary disability and the DTV has availability to serve a family as needed.

Parent choice. Just as parents sometimes choose to have a speech therapist with no DT support, they might choose to have a DTV with no DT support.



2. **DT with no DTV**
The child has multiple impairments including a visual impairment and the parents choose to decline DTV services.

Parent choice. Just as parents sometimes choose to have a DT while not accepting any of the other offered therapy services, they might choose to have a DT with no DTV support even though the child has a visual impairment.



3. **Situations when services from both a DTV and DT might be appropriate.**
4. When a DTV has limited availability in your area. In this case a DTV might work together with a family and a DT on a limited basis. The DT can carry out the suggestions from the DTV on a more regular basis.

5. If a child has multiple disabilities and the DT in your area has a better background for this. In this case, the team might decide to have the DT come half the time and the DTV come the other half. The IFSP team might decide the family needs weekly support from the DT while the DTV could come in less often to offer the vision component that is needed.

6. If a child is diagnosed with Cortical Visual Impairment (CVI), use of a DTV together with a DT is important. This is a special case in which the DT and DTV will serve completely different roles. The DT should be used to meet the general developmental goals. The DTV will need to focus heavily on the child's visual needs. Depending on the severity of the case, a DT and a DTV may both be needed on a frequent basis.

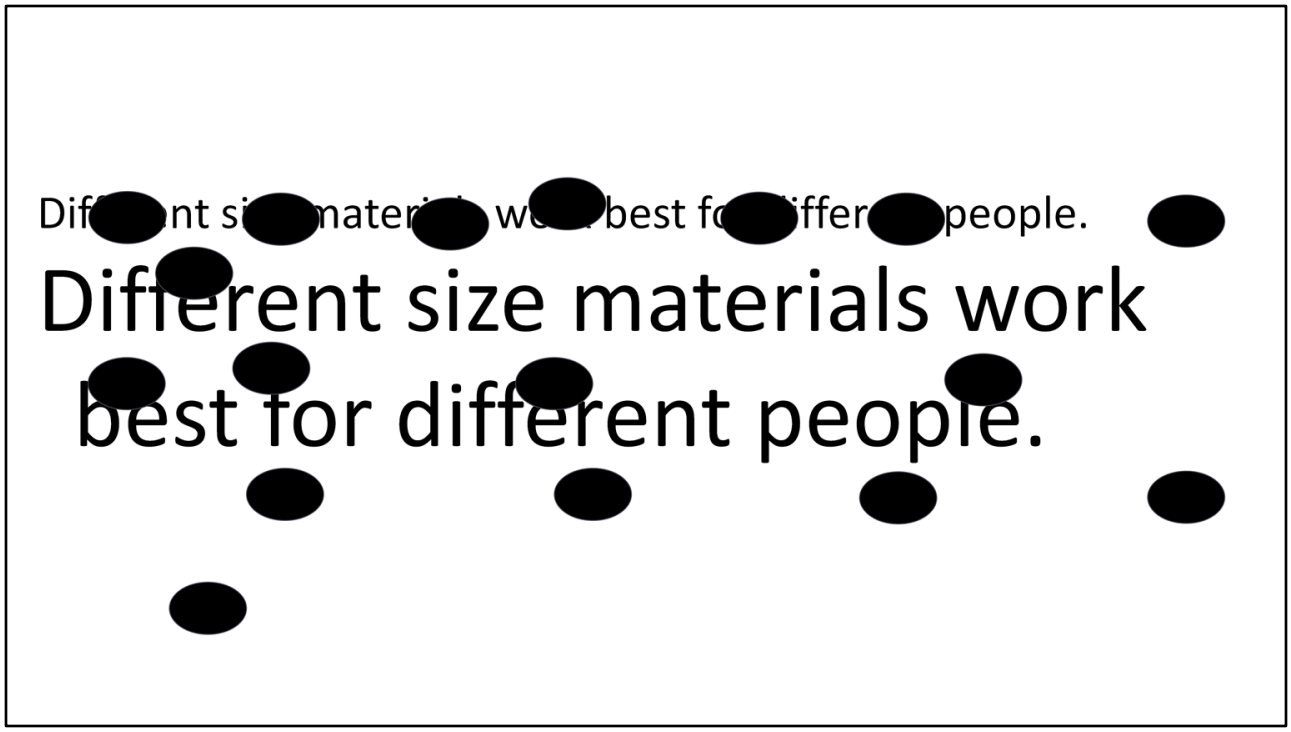
7. A parent may simply choose to use a DTV in conjunction with a DT. Perhaps the team has recommended once a week for both services and the parents do not want that much intervention. In this case, encourage a family to keep at least some contact with a DTV because of the specialized services and resource that are available.

Strategies

Different size materials work best for different people.

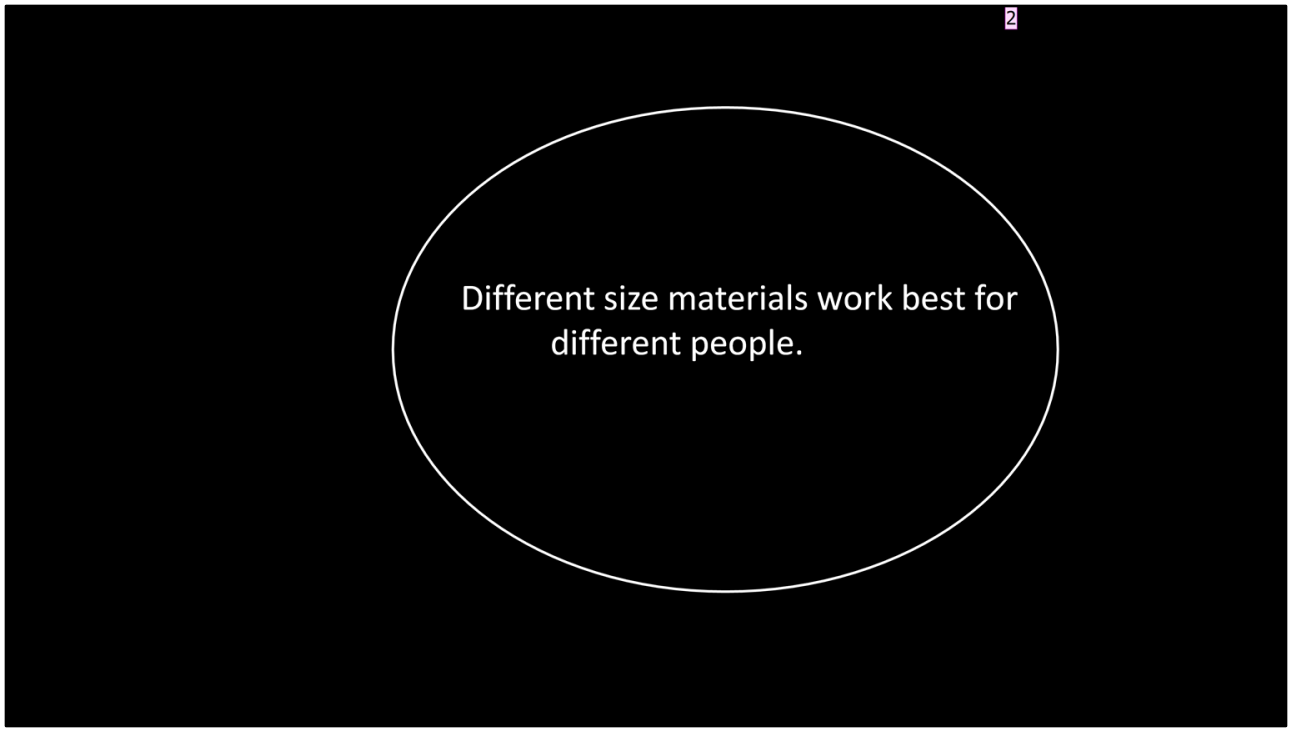
Different size materials work best for different people.

Just like a child's visual needs and abilities cannot be assumed based on their visual condition, the strategies that would serve them best cannot be determined based on the fact that they have a visual impairment, or their specific visual condition. Here are some examples.

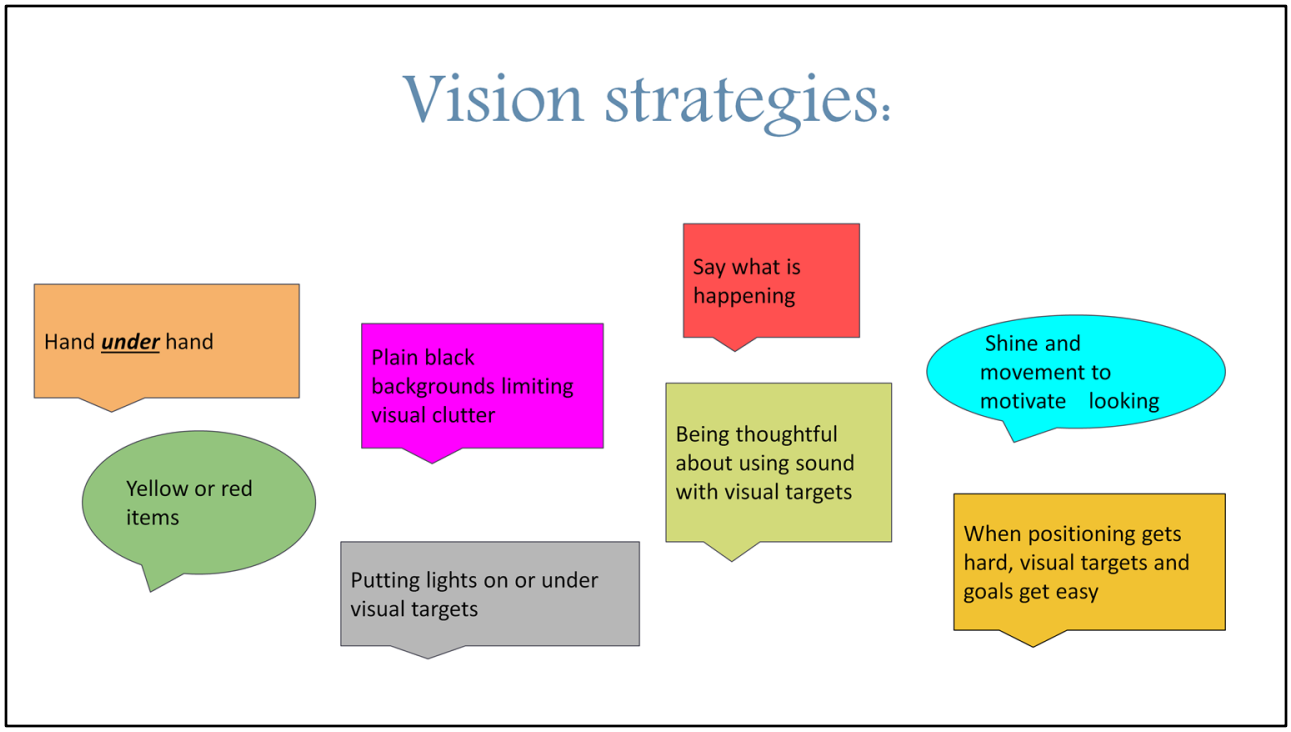


If a child had a scattered field loss, larger materials may work better for that child.

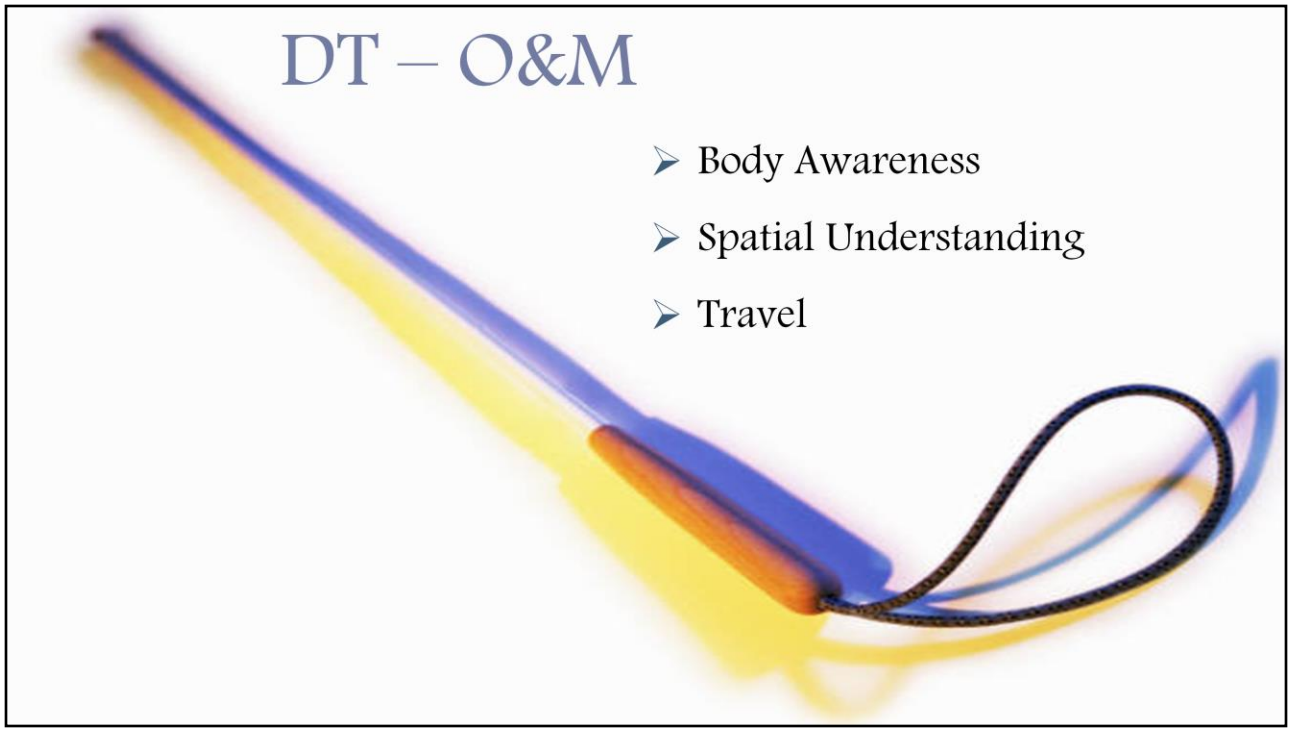
However, large materials may not work well for a child with peripheral field loss. In that case,



smaller materials may work better



These are some common strategies that a DTV may suggest for an infant or toddler who has a visual impairment, depending on their specific needs, current level of development, family routines and family priorities.

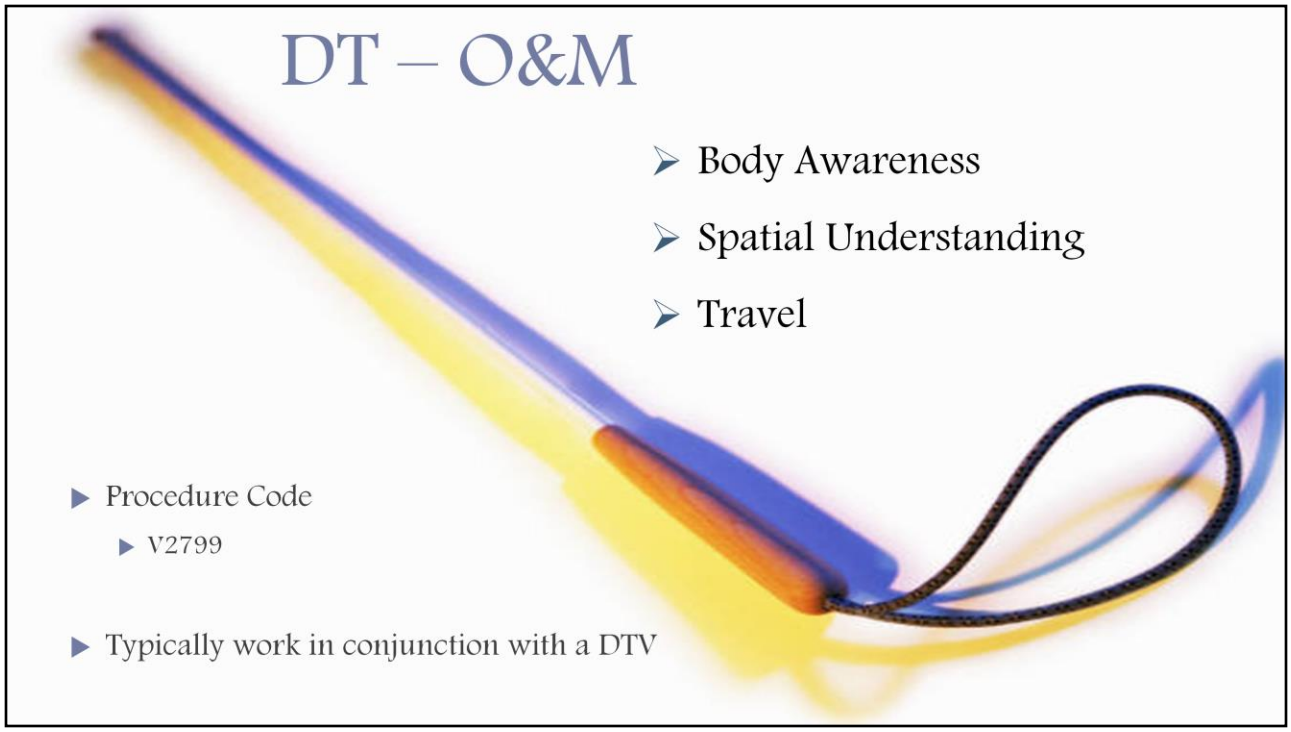


A DTO&M is a specialist in the vision field.

1. The person holds a master's degree in Orientation and Mobility , a discipline which focuses specifically on safe travel and spacial awareness for individuals with vision loss. When dealing with infants and toddlers, the DTO&M will focus on body awareness, spatial understanding, environmental concepts, and travel.
2. This could potentially graduate to beginning white cane use for older toddlers.

The DTO&M serves a critical role in helping families teach their child about the world beyond the child's reach. For example, children with very low vision and children who are blind require experience to understand foundational environmental concepts such as what a door is before they can learn to open and move through a door. In addition, children must learn spatial concepts such as up and down, behind, left and right.

A DTO&M might also be consulted with for the child who is on target for mobility, and is now ready for independent forward movement. This will require pre-cane devices and travel techniques. It is very important that a child learn correct travel techniques from the beginning. Improper or unsafe habits are almost impossible to "unteach" once they are formed.



3. A DTO&M is authorized under Vision. The code for such service is V2799.
Since a DTO&M is used for children who have a visual impairment, they would almost always be working in conjunction with a DTV. Typically a DTV will be involved with a case before DTO&M services are needed. Check with the child's DTV to find out if a DTO&M referral is right for the child.

CRITICAL IMPORTANCE OF FAMILY PARTICIPATION

Experience–based

Family routines

Collaboration

photo: https://nihrecord.nih.gov/newsletters/2015/07_31_2015/story7.htm

Children with visual impairments learn by doing, not by seeing!
Family routines provide needed repetition.

Many delays that result from visual impairment are due to lack of experience with the environment and materials within the environment. Also critical to learning is the relationship-base for experience. For this reason it is imperative that parents and DTVs/DTO&Ms collaborate. This assists parents in gaining skills and confidence as they interact with their child on a daily basis even when the DTV/DTO&M is not present. Integration of strategies into family activities within daily routines will provide frequent exposure to developmentally rich experience. Such an approach will assist families in reaching their identified goals.

It is imperative that DSCs communicate the need that parents actively participate in DTV and DTO&M sessions. Family-centered relationship-based practices are the most appropriate approach especially when a child has a visual impairment.

Finding a DTV

- Procedure Codes
  - V2799 Direct Individual Vision Service
  - 99499 Direct IFSP Meeting/Development
- Contact Illinois School for the Visually Impaired (ISVI) for help.

1. The Authorization Codes for a DTV providing ongoing services are found under Vision. Make sure you are authorizing a DTV and not an optometrist. The DTV service codes are V2799 for direct individual vision service or 99499 for direct IFSP meeting/development.

2. If you cannot find a DTV with availability to provide ongoing DTV services, call Hearing and Vision Connections. We keep in close correspondence with all credentialed DTVs. We also keep in close contact with those working to become credentialed. When a need is identified, we will work with you to find someone to serve the family. Often DTVs will agree to cover areas outside their typical service area when asked.

Deaf-Blind Services

Philip Rock Services/Project Reach: IL Deaf-Blind Services
818 DuPage Blvd.
Glen Ellyn, IL 60137
(630) 790-2474 (voice)
(800) 771-1158 (TTY)
(630) 790-4893 (fax)
PRC@philiprockcenter.org

Website: www.philiprockcenter.org

When a child has a combined vision-hearing loss, he/she should always be referred to our state's program for deaf-blind services. In Illinois, that is Project Reach. They cover services to individuals who are deaf-blind ages birth to 21. These are free services. They provide information, training, and in-home consultation to families and therapists in the lives of children with deafblindness. They do not provide DTV, DTO&M, or DTH services. A brochure that describes their role in early intervention is in your handouts.

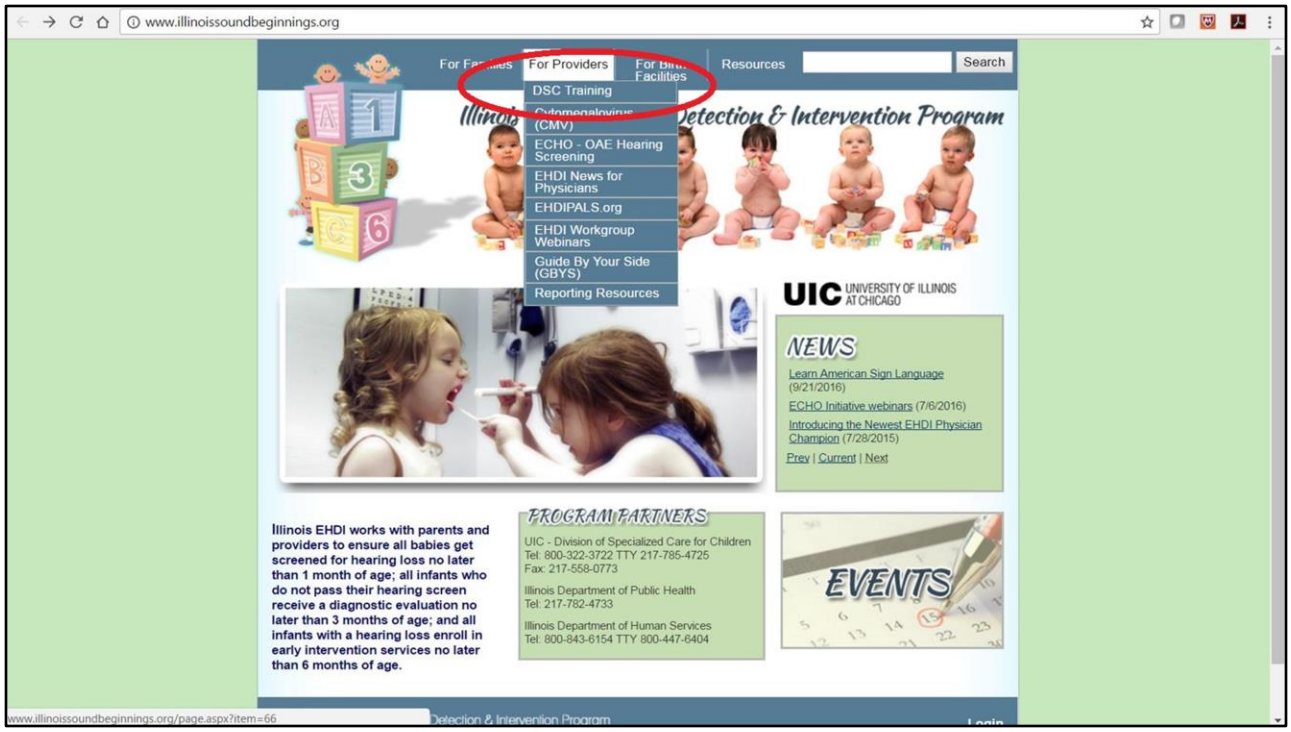
Early intervention is driven by family choice. Some families may wonder if vision or hearing services are critical to address child development. This handout helps to address some basic facts about the the potential impact of sensory loss on development. This information may not change a family's choice, but allow them to make an informed choice. It is also available in Spanish. The English version is in your handouts.

- Support Contact:
  - Andrea Marwah
  - 708-409-8800
  - Andrea.marwah@illinois.gov
  - www.soundbeginnings.com

Website Link

This is where all your training materials will be housed.

http://www.illinoissoundbeginnings.org/


www.illinoissoundbeginnings.org
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Resources
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EHDIPALS.org
EHDI Workgroup Webinars
Guide By Your Side (GBYS)
Reporting Resources
Detection & Intervention Program
UIC UNIVERSITY OF ILLINOIS AT CHICAGO
NEWS
Learn American Sign Language (9/21/2016)
ECHO Initiative webinars (7/6/2016)
Introducing the Newest EHDI Physician Champion (7/28/2015)
Prev | Current | Next
Illinois EHDI works with parents and providers to ensure all babies get screened for hearing loss no later than 1 month of age; all infants who do not pass their hearing screen receive a diagnostic evaluation no later than 3 months of age; and all infants with a hearing loss enroll in early intervention services no later than 6 months of age.
PROGRAM PARTNERS
UIC - Division of Specialized Care for Children
Tel: 800-322-3722 TTY 217-785-4725
Fax: 217-558-0773
Illinois Department of Public Health
Tel: 217-782-4733
Illinois Department of Human Services
Tel: 800-843-6154 TTY 800-447-6404
EVENTS
www.illinoissoundbeginnings.org/page.aspx?item=66
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