Article • Integrating Social Work Services in an Established Low Vision Service: Lessons Learned from a One-Year Pilot Program

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ABSTRACT

Background: Individuals with visual impairment face challenges in addressing transportation access, employment placement, and mental health awareness and counseling. Accessing resources is difficult for patients and providers lacking training. Social workers can bridge these gaps. This paper reviews lessons from integrating a new social work service into an existing low vision clinic.

Methods: The Low Vision Service at The Eye Center of the Southern College of Optometry received a private grant to hire a social worker (SW) for one year. The social worker kept a log of all the patients with whom she interacted during this term. Using the patient logs, a record review and assessment of interactions with each patient were evaluated.

Results: The SW evaluated 236 patients. Case management and referrals comprised the majority of the SW's efforts, as requested by patients. Counseling and emotional support were rarely implemented by the SW. Program sustainability was a challenge.

Conclusions: While our program provided requested support to our patients, it functioned more as a patient navigation and case management program than one that highlighted the SW's expertise. Incorporating patient input and creating a structured internal program and education for appropriate referrals, as directed by the SW, would have provided an opportunity for a more robust program highlighting the key skills a SW can offer.

Keywords: low vision, patient navigation, social work

Introduction

Individuals who are blind or visually impaired face significant challenges in public spaces, home environments, and vocational and educational settings.[1,2] Within most communities, barriers, such as inaccessible transportation, inadequate signage, and poorly designed digital platforms, can limit independence and increase the risk of mental health concerns and social isolation.[1,2]

These barriers may be deepened by financial limitations, social determinants of health, and poor health literacy, making it difficult for individuals to access essential rehabilitation services or manage individualized health needs.[3]

In one's home environment, interventions are geared toward improving safety, reducing falls, and aging in place.[1,4] Individuals with vision loss frequently require adaptations tailored to their own needs, such as tactile marking, auditory solutions, or assistive technology. While these assistive and adaptive tools promote safety and self-sufficiency, they are not necessarily covered by medical insurance and can prove costly.[4] Families, friends, and caregivers may also experience emotional stress when struggling with the functional and emotional impacts of newly diagnosed visual issues.[4] This transition proves challenging without adequate rehabilitation training or support from one trained in vision rehabilitation or understanding the functional impact of vision loss and new limitations that develop, thus adding to the difficulty of maintaining independence and safety at home.[1] The cost burden can make essential modifications inaccessible to many.[4,5]

Employment also poses a challenge.[5] Despite evidence that accommodations for visually impaired workers are inexpensive and effective, misconceptions about productivity and costs remain widespread among employers.[4-6] As a result, people with vision loss experience significant rates of unemployment or underemployment. This financial instability restricts access to assistive technology and other crucial resources, perpetuating an ongoing cycle of dependency and exclusion.[6]

Knowledge of how to access resources and services directed towards vision rehabilitation, as well as learning coping methods to adapt to vision loss,

can be difficult for patients without guidance. Since this is not a significant part of the training of eye care physicians, interprofessional collaboration can improve rehabilitation outcomes for patients who need assistance beyond assistive devices. Social work is a critical support mechanism to addressing these barriers.[7]

Social workers can connect blind or visually impaired individuals to financial assistance programs and advocacy resources, while also providing vital counseling and caregiver support. Quinn noted that systemic barriers within social work itself, such as limits in funding and organizational capacity, along with complicated referral pathways and qualification criteria, can impede service uptake.[7] These challenges impede individuals from pursuing and obtaining appropriate support for their daily activities. That said, social work provides crucial support assistance to patients, assessment of counseling needs, and resources for patients in need: all areas optometrists lack training in.

To address the needs of the low vision population in Memphis, Tennessee and surrounding areas, Southern College of Optometry received a private grant to provide funding for a part-time (16 hours per week) social worker (SW) for patients evaluated at The Eye Center (TEC) in the Low Vision Clinic for one year. The SW hired for this position had over 30 years of experience working in a hospital setting prior to working at TEC. In that role, she assisted patients with community resources upon discharge from the hospital, mental health assessments, and counseling, and she connected families to housing and transportation services in West Memphis, Arkansas. Her role provided support in a community that lacked reliable public transportation and had high levels of poverty, which provided some alignment with the patients seen in TEC.

TEC had not employed a SW in the past, and thus this was a new service in terms of scheduling, billing, and coding. All doctors in the Low Vision Clinic had worked with SWs in the past, either during their optometric residencies or during previous employment before working at TEC. Given the known alignment of vision loss and mental health issues, the expectation was that the SW would identify people through either the intake process or after the low vision examination and provide onsite counseling and connect patients to appropriate community resources. There was also a plan for a support group if patients and family members required more support beyond the SW's available time.

This study assessed referral patterns and outcomes of patients who interacted with our SW for that year and provided observations of successes and failures of the program. The two main areas of concern were tracking the outcomes of referrals and the use of SWs for mental health assessments.

Methods

The SW hired for this position was trained on EMR, Microsoft products, and policies and procedures specific to optometry and TEC. All new and established patients who presented for consultation or yearly examination were targeted by the SW to provide an intake via phone before their low vision examination to ask questions to screen for health literacy, emotional adaptation to vision loss, and the need for referral for services. If services were identified as a point of need, the SW scheduled a face-to-face appointment with the patient in her office after the patient's low vision examination. The SW had an office where she could meet either alone or with family to discuss needs or to counsel the patient on mental health needs separate from the clinic. The SW kept a patient log of contact with patients, types of referrals, and outcomes of referrals. Patients were asked to prioritize their needs when meeting the SW, and services and referrals were ranked by the patient. Descriptive statistics were used to evaluate patient demographics and program outcomes.

Results

The SW served 236 patients during the study period. Six patients were referred from outside the Low Vision Clinic: from the ocular disease department (n=3), primary care (n=1), contact lens (n=1), and vision therapy (n=1). For these specific referrals, assistance was requested for emergency housing, materials (glasses), substance abuse rehabilitation, and abuse (assistance with mandated reporting).

Among the patients the SW identified through intakes for low vision, 57.4% were female (n=132) and 42.6% were male (n=98). Reported race was varied, with 2/3 people reporting their race as black. The most common conditions observed in this group were primary open-angle glaucoma (POAG) (n=43), macular degeneration (AMD, exudative and non-exudative) (n=43), Hereditary disease (n=24), optic atrophy (n=23), and diabetic retinopathy (proliferative and non-proliferative) (n=22, Figure 1).

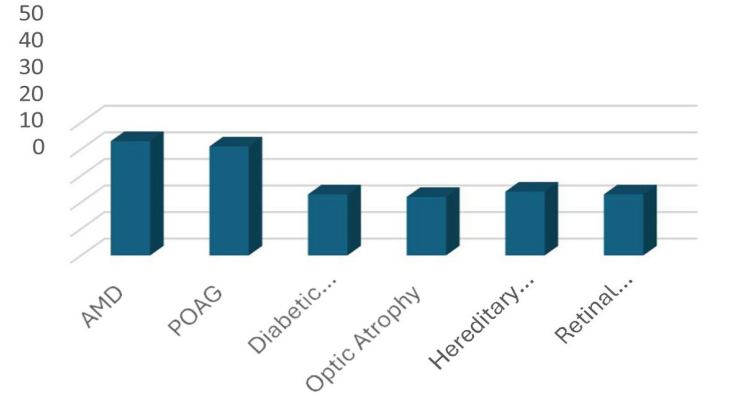

Figure 1. Most common disease presentations

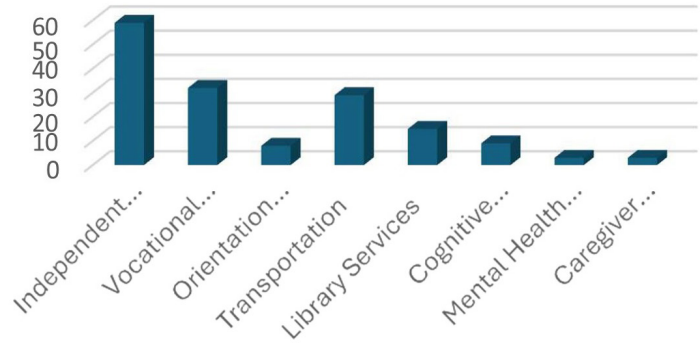

Figure 2. Distribution of referrals

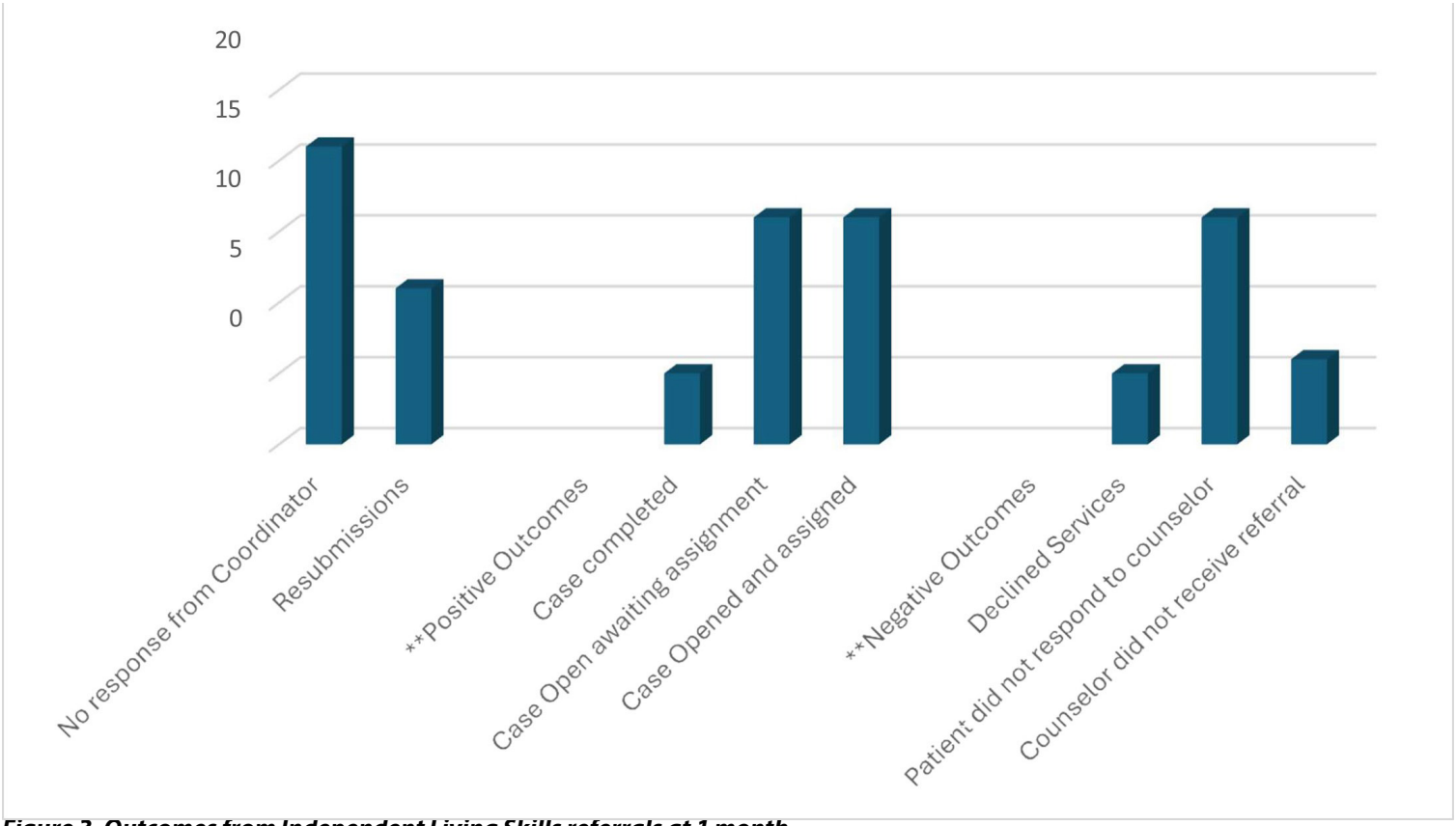

Figure 3. Outcomes from Independent Living Skills referrals at 1 month

For each patient, the SW identified primary concerns as well as secondary or, in rare cases, tertiary concerns, as identified by the optometrist or patient. Concerns were identified for minors by parents, guardians, and managing optometrists. The SW also offered depression and cognitive screenings if concerns were noted during the examination by a managing optometrist.

The most common referrals for patients who required assistance were for state-funded services (n=99) through the Department of Human Services. These are services that help patients who meet specific visual criteria either improve function and safety in the home or learn skills to become job- or college-ready. External programs such as transportation and library services were often requested by the patient or the managing optometrist. Mental health and cognitive screenings were less common and referred for in lower frequencies. See Figure 2 for distribution of common referrals.

Follow-up on referrals was another responsibility of the SW. Due to staffing issues with the Tennessee DHS vocational rehabilitation office throughout the year, the SW was unable to obtain consistent

feedback on training and placement for vocational rehabilitation or the associated orientation and mobility program. However, the regional coordinator for Independent Living Skills provided feedback on referrals when requested. Independent Living Skills cases include an in-home assessment with the patient and family and an intake relating to the patient's needs in their home environment. Adapting appliances, lighting evaluations, talking devices, and portable assistive technology are often within the scope of assessment by an Independent Living Skills Rehabilitation Teacher. Visits and recommended technologies are fully covered by state funding.

Of the patients referred for Independent Living Skills through the Department of Human Services (DHS) by the managing optometrist, 99 referrals were sent on behalf of our patients for Independent Living Skills, with 11 of them being resubmissions for patients who did not receive services at the time of their initial referral. Outdated contact information, not answering a phone when not recognizing the phone number, and never being called were reasons reported anecdotally by the doctors that patients had given when asked why they did not accept services at subsequent exams.

For patients who were successfully referred, follow-up for referrals at one month was mixed. The DHS coordinator did not respond when asked to follow up with 21.2% of patients (n=21). Of the remaining 78 participants, only thirty-nine (n=39) had confirmed contact and action in their case from the coordinator. Conversely, almost a third of patients (n=27) referred to Independent Living Skills did not have their cases opened at the one-month point. Lack of interest in services was noted by a few (n=5), but more significantly, lack of response from patients when contacted by DHS (n=16) was the primary reason cases did not open. Please see Figure 3 for case status for patients referred for Independent Living Skills at one month from referral.

Per the patient log, when the SW attempted to call patients who had not responded to the DHS Coordinator's attempts to establish a case, the phone number was disconnected, the phone number was documented incorrectly on the referral, or there was no response to the SW for follow-up. With ongoing feedback from those not receiving services, the SW adapted protocols to ensure that demographic information was updated in the patient's chart and referral before forwarding to the coordinator as well as sending encrypted emails rather than faxing to a general office fax.

Mental health assessments were not commonly requested by doctors or patients. Counseling services were limited to 1-2 visits for patients or caregivers, with some patients being referred to psychology or psychiatry based on the SW's recommendation for counseling. While patients were asked whether they had depression or anxiety related to their vision loss in the intake with the SW, actual requests for counseling were low, either from the patient or doctor examining the patient, with regard to assistance with the management of depression or anxiety. Opportunities for telehealth visits may have increased the uptake of services for patients who had transportation issues; however, telehealth service was not available at the time in TEC. Transportation was a common request for resources, and the ability of patients to meet with the SW may have been limited by transportation barriers or prioritization of needs when the patient met with the SW in person.

Discussion

SWs have a wide range of skills that benefit visually impaired individuals in either working alongside eye care physicians, either internally or as referral sources to which eye care physicians can refer.[8] It has been demonstrated that when social work is integrated into eye care facilities, the identification of patient needs and referral for assistance with resources for medications or transportation has improved outcomes for patients.[9] In the visually impaired population, access to resources, assessment of mental health challenges, and learning skills for self-efficacy and empowerment are the key areas of assistance provided by SWs.[9]

Mental health issues are significant in patients with visual impairment, and their support systems often report that there are insufficient resources to address them.[10,11] In a study by Hark et al., the addition of social work services in a glaucoma clinic found that patients responded positively, especially in terms of managing identified depression symptoms.[9] One important difference that Hark et al.'s study demonstrated from our program was the employment of targeted, validated questionnaires to screen patients for their mental health issues, where our SW asked a patient if they were experiencing depression or anxiety. Since such a small percentage of patients self-identified or were identified as needing attention to their mental health status, adjusting the intake process or asking

patients more targeted questions during their eye exam would likely have identified more patients with depression or anxiety. In our clinic, the identification of mental health issues was low relative to published studies of visually impaired individuals.[9] This may have been due to a lack of targeted questioning of the patient or a change in prioritization of the need for resources from external needs (transportation, employment, home modifications) to internal needs (adaptation to vision loss, depression, and anxiety).

Given the wide variety of resources available, patient-perceived need versus a SW assisting patients in identifying a more comprehensive set of needs likely played a role in long-term success/satisfaction. In our study population, patients often self-identified the resources needed, and our SW adapted most of their time to coordinate resources for patients and families. However, connecting patients to services they were unaware of helped with a range of needs: transportation, employment, home modifications, and hobbies. While we did not perform satisfaction surveys for patients who met with the SW, documentation of patient satisfaction was noted once the case was closed and referrals were made.

Ultimately, the SW functioned more as a patient navigation system rather than providing an assessment of our patients' and families' individualized needs. An innovative and effective response to identifying barriers and providing patient-centered resources is a patient navigation system which connects patients with resources targeted to their specific needs.[12] One such program with positive results was implemented by the Department of Ophthalmology of the University of Pittsburgh. Zarnegar et al. reported their findings when their department implemented a program that employed a dedicated patient navigator to help individuals identify obstacles and target requested resources, such as assistance with transportation, insurance, and financial barriers, while addressing health literacy gaps.[12,13] The most common reasons for referral were "transportation, insurance, and assistance with medical appointments and equipment."[13] This differed from our patients' prioritized list of goals; however, our department focuses on rehabilitation due to vision loss and thus, it makes sense that our patients received assistance with resources geared toward rehabilitation and vision loss rather than medical management.

According to Zargenar et al.'s research, the system used at the University of Pittsburgh received 130 referrals for 125 patients; 98% of these cases were addressed, and 90% were fully resolved in three months.[13] This was more efficient than our program, although differences could be related to the later timing of the navigator working with the patient, better attention to updating demographics during scheduling appointments, and staffing of requested programs in Pennsylvania compared with Tennessee and surrounding services. Since a significant number of our patients were referred to a program with strict visual criteria, that may have created a bottleneck in referrals compared to some of the programs that Zargenar et al. noted their patient navigator worked with. Moreover, navigators in the Pittsburgh system ensured that educational materials were provided in accessible formats and assisted patients in completing the medical paperwork; this was not an identified resource that the SW utilized and may have contributed to reduction in uptake of services as well. Had the Low Vision Service utilized this model, this would have freed more time for our SW to use her specialized skills where needed.

Cost is also a major factor when comparing available support models, especially when looking at program sustainability. Traditional social work programs often require significant funding for benefits and training while serving a diverse population and services specific for individuals with vision impairment may require further training.[7] State blindness agencies provide specialized rehabilitation, vocational training, and assistive technology assessments; however, their services are often restricted by eligibility requirements or long waitlists and do not extend to mental health counseling or individualized needs like transportation resources.[4] In contrast, the University of Pittsburgh's patient navigation system demonstrated a lower-cost, targeted approach without the administrative overhead of other programs.[13] A significant number of our patients self-identified the need for rehabilitation and assistance in their home environments, or this was recommended by doctors without the assessment of the SW. Home adaptation is a common need for people with visual impairments.[14] Given the shift to patient-directed requests for resources, this suggests that patient navigation may be a cost-effective complement to both social work and state blind services, particularly in addressing immediate financial, emotional, and health literacy barriers.

In our limited time and experience with SWs, there were many lessons learned. One issue we identified was identifying patients' needs before implementing the program, and developing the program with that in mind would have led to a better program design. While the initial plan was to tailor services to what we

had assumed were patient needs, focusing on mental health assessments and counseling, it quickly evolved into a patient referral center with a case management focus. While this served the patient's self-identified needs, it likely also missed key assessments and questions that typically arise during a low vision exam.

Since TEC is a teaching facility, a fourth-year intern provides the initial clinical assessment and is overseen by an experienced, residency-trained optometrist. Identification of cues and signs of depression during an exam or phrasing of questions can be sophisticated skills, and thus may be missed by optometric interns, who have limited experience with this population. Identification and timely referral for assessment and counseling for mental health care were likely lower given how few patients received mental health counseling by our SW compared to reported national statistics for this population. The SW used general questions about the patients' perception of their adaptation to vision loss rather than validated mental health scales that target anxiety and depression. For future considerations, creating a program with the input of a licensed SW and surveying patients for their perceived needs before implementing this program would have been a better approach to achieving successful outcomes. Moreover, incorporating an assessment tool for outcomes would have been helpful for long-term outcomes; once the SW's year term ended, our clinic had no follow-up on the outcomes of this group, which impeded our ability to truly see the benefits of this program.

Finally, given that the SW was only part-time, the SW adapted her interactions with patients to maximize time with patients to the patients' prioritized needs, rather than providing a structured assessment with a broader scope of patient emotional status, self-efficacy, and general well-being and safety. Upon 6- and 9-month program evaluations, the SW had adapted her limited schedule to phone intakes and brief encounters with patients, given the volume of patients referred after their low vision exam and the case management piece. While this points to a significant number of needs of our patients in terms of referrals, some referrals from optometrists were school forms and paperwork that could have been completed during the optometric exam. Education and training of clinic optometrists would have improved the efficiency of appropriate referrals to maximize the skill set of SWs.

Another lesson was to identify a sustainable mechanism for funding the program. Our clinic had no experience with billing and coding for services specific to social work. Given our outpatient clinic status, coverage for services was nonexistent with the majority of insurance our patients presented with. In our unique situation, the clinic had grant coverage for the SW's salary, but beyond one year, coverage of her services was not possible in TEC's clinic setting or budget.

Although the benefits of a SW's approach to patient care are invaluable, the budget at our clinic could not absorb the costs of a SW beyond the grant period, and we were unable to continue providing that service to our patients.

In our current situation, the use of a patient navigation system for resources run by a person with working knowledge of local resources would benefit patients seen in our clinic if we were to proceed with a model informed by this short experience. Even utilizing artificial intelligence (AI) programs to create a list of current resources based on patient needs could be explored for our patient population.[14] Since our program was not self-sustainable and could not satisfy some of our patients' needs, we identified a local social service that assists in identifying appropriate resources for patients going forward. Currently, our clinic refers to a local community disability advocacy program (Disability Connection Mid-South, Memphis, TN, USA) that provides resources to patients with disabilities from transportation and vocational support to advocacy training and support groups and activities.

While an optometrist knowledgeable of resources can provide information for patients, the time and effort of creating and updating current resources exceeded our doctors' available time and reduces clinical assessment time with the patient and educational opportunities with our interns. From an efficiency standpoint of maximizing doctor-patient time, AI may be a useful tool providing confirmation of local services and communication of findings to patients would still require a knowledgeable person to provide valid and supportive resources.[15-17] However, research on the use of AI in this type of resource list generation and application is limited, and research and anecdotal reports have shown that some resources are not always current.[15]

Conclusion

This one-year pilot program providing social work services for low vision patients at TEC had mixed results. While the SW provided targeted case management and assisted with referrals, aspects of the strengths and benefits of the scope and management that SWs could offer were limited to case management and referrals, rather than holistic care. Surveying patients to assess their needs as well as collaborating with a SW early in the process of developing the program would have helped utilize more of the expertise SWs can offer and allow for an exchange of ideas to highlight those skills for better outcomes for our patients. Patients often have competing needs, and the direction from our SW was a crucial piece that was not always assessed given the overwhelming number of referrals. Additional training to staff and faculty and, in our clinic's case, interns or having an in-service performed by the SW may have created opportunities for more diverse care and services the SW could provide. While our 1-year pilot program did not yield success, the lessons learned from our shortcomings can help inform programs that intend to implement this type of help and resource for visually impaired patients.

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