Falls among Adults
Aging with Disabilities

National Falls Prevention Resource Center
Center for Healthy Aging
National Council on Aging

March 3, 2016
About the National Council on Aging

Our Vision:
A just and caring society in which each of us, as we age, lives with dignity, purpose, and security

Our Mission:
Improve the lives of millions of older adults, especially those who are struggling

Our Social Impact Goal:
Improve the health and economic security of 10 million older adults by 2020
National Falls Prevention Resource Center

- Funded by the Administration for Community Living/Administration on Aging
- Increase public awareness and educate consumers and professionals about falls risks and how to prevent falls.
- Serve as the national clearinghouse of tools, best practices, and other information on falls and falls prevention
- Support and stimulate the implementation, dissemination, and sustainability of evidence-based falls prevention programs and strategies
- Began September 2014 – two-year grant
- www.ncoa.org/healthy-aging/falls-prevention/
Presenters

• Ivan Molton, PhD
  University of Washington School of Medicine
  RRTC on Healthy Aging and Physical Disability

• Michelle H. Cameron, MD, PT, MCR
  Department of Neurology
  Oregon Health & Science University
  MS Center of Excellence-West
  VA Portland Health Care System

• John Kingston, MA, COMS
  Supervisor of Orientation & Mobility and Comprehensive
  Neurological Vision Rehabilitation (CNVR)
  Department of Veterans' Affairs
  Western Blind Rehabilitation Center
Falls in People Aging with a Long-Term Disability: Prevalence, Risk Factors, and Impact

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Patti Noritake Matsuda, PT, PhD, DPT
University of Washington
Department of Rehabilitation Medicine
The contents of this presentation were developed under a grant from National Institute on Disability, Independent Living, and Rehabilitation Research (NIDILRR grant number 90RT5023-01-00). NIDILRR is a Center within the Administration for Community Living (ACL), Department of Health and Human Services (HHS). The contents of this presentation do not necessarily represent the policy of NIDILRR, ACL, HHS, and you should not assume endorsement by the Federal Government.
Aging with versus aging into disability
Currently 12.4% of US Population are >65 (37.3 million)
- By 2030, expected to be 20.4% (71.5 million)
When we talk about falls in older adults, we usually mean this group.

- Aging *into* disability means greater risk of medical conditions associated with growing older
  - Osteoarthritis
  - Heart Disease
  - Diabetes/diabetic amputation/polyneuropathy
  - Cognitive impairment
  - Stroke/Hemiparesis
- These contribute to greater fall risk
  - problems with balance, strength, proprioception, judgment, mobility impairments requiring mobility aids, etc
Falls are an essential intervention target for those aging into disability.

- Annual incidence in those >65 is 30%
- Of these, ~10% are injurious
- Injurious falls are associated with greater overall health care costs and diminished quality of life
Aging with disability
Aging “with” disability

- In 2010, 29.5 million Americans aged 21-64 (16.6% of the working age population) reported physical disabilities
- 260,000 individuals with Spinal Cord Injury
- 350,000 individuals with Multiple Sclerosis
- 100,000+ individuals with Charcot-Marie-Tooth
- 177,000 individuals with Post-Polio Syndrome
Aging with disability

- **Spinal Cord Injury**
  - Average age now ~ 40 years
  - 40% are over age 45
  - Average age at onset increased from 28.7 to 38.0 from 1973

- **Multiple Sclerosis**
  - Mean age 49-53 years
  - 42% over the age of 65

- **Post-polio syndrome**
  - 90% are over the age of 55

- **Cerebral Palsy**
  - Death in childhood is now rare (about 2%)
  - 86% of those who survive childhood will live past age 50
Falls exist in a unique context for this population.
What do we mean by *falls*
Definition of a Fall

- Many different definitions exist

- Commonly used:
  - “Unexpected event in which a participant comes to rest on ground, floor, or lower level”
Definition and Types of Falls in the Literature

- **Fall**
  - Unexpected event in which a participant comes to rest on ground, floor, or lower level

- **Recurrent Falls**
  - 2 or more in a set time frame

- **Injurious Falls**
  - Falls that require medical attention
    - Ranges from cuts/contusions to TBI or broken bones
Consequences to the Individual

- Injury and hospitalization
- Loss of independence
- Fear and loss of confidence

- Health consequences of limited physical activity
  - Reduced strength
  - Reduced balance
  - Reduced stamina
  - Increases your chance of falling

Fall

Fear of falling
Restricted Activity

Decreased Strength Balance Gait
Definition of a Fall

• Do you ask your patient about falls?

• Do you define falls for your patient?

• How do you think your patient(s) defines a fall?
  – Landing on the floor?
  – Associated with injury?
Falls in the Medicare Population

- Fewer than half (48%) Medicare beneficiaries reported talking to their health care provider (HCP) following a fall
  - 60% of these reported receiving fall prevention information
  
  - Shumway-Cook et al., 2002
How does falling differ in the context of aging *with* disability?
Individuals aging with disabilities

• Have a greater number of secondary conditions/medical comorbidities (e.g., osteoarthritis)

• Have lower overall levels of physical activity
  – Associated with weakness, decreased balanced and impaired gait

• Often use aids for mobility

• Still need to carry on with daily activities and life participation!
Example: Falls in wheelchair users with SCI

- Falls in SCI are often associated with transfers
  - Chair to chair, chair to bed, chair to commode, etc
- Individuals with SCI may be unable to get up after a fall
  - This creates considerable risk for pressure ulcers and other complications
- Individuals with SCI are more likely to experience injurious falls
  - SCI associated with greater risk of facture
- Injuries are associated with additional risks, such as autonomic dysreflexia
## Falls & Injurious Falls by Disability Diagnosis (RRTC; n= 1877)

<table>
<thead>
<tr>
<th>Population</th>
<th>Falls (last 6 months)</th>
<th>Injurious Falls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multiple Sclerosis (MS)</td>
<td>54.5%</td>
<td>22% of falls</td>
</tr>
<tr>
<td>SCI</td>
<td>40%</td>
<td>20.7% of falls</td>
</tr>
<tr>
<td>Muscular Dystrophy</td>
<td>69.6%</td>
<td>19.9% of falls</td>
</tr>
<tr>
<td>Post-polio syndrome</td>
<td>55.1%</td>
<td>22.7% of falls</td>
</tr>
</tbody>
</table>

UW RRTC on Aging and Physical Disability; NIDILRR grant number 90RT5023-01-00.
What do we know about risk factors for this population?
Example: MS Risk Factors in the ICF Framework

- **Body Structure & Function (Impairments):**
  - Strength
  - Flexibility
  - Sensation
  - Perception
  - Cognition
  - Balance
  - Gait

- **Functional Activities (Limitations):**
  - Sitting
  - Standing
  - Walking
  - Transfers
  - Reaching

- **Participation (Disability):**
  - ADLs/IADLs
  - Work
  - Recreation
  - Mobility (Community)

- **Personal:**
  - Fear/Self-confidence
  - History of falls

- **Environmental:**
  - Home/Work/Community
Age

• In people with disability, the effect of age on fall risk appears to be curvilinear
• Falls incidence peaks in middle age (55-64)
• This may be a proxy for activity level and expectations in the context of worsening impairment
• In adults aging with disabilities, the conversation about falls prevention needs to start sooner
Mobility and Activity Level

• Greatest fall risk was for those who were walking with an assistive device ("moderate" limitations in walking)

• In individuals with SCI, higher levels of physical activity were associated with greater fall risk
Mobility and Falls Risk (Matsuda et al., 2015)
Mobility and falls: Proposed relationship

- Mobile and stable
- Mobile and unstable
- Immobile

Matsuda et al., 2012
Coote et al., 2014
Fear of Falling

• Fear of falling is multifactorial
  – Legters, 2002

• Present in those who have not fallen
  – Nilsagård et al. 2009, Matsuda et al., 2012

• Associated with injurious falls in MS
Fear of Falling

• In RRTC data, fear of falling is prevalent
  – In muscular dystrophy, 68%
  – In MS, 52%
  – In SCI, 40%
  – In post-polio syndrome, 54%

• Fear of falling is associated with reduced physical activity (even after adjusting for level of physical impairment)
Secondary Conditions

• Weakness
• Trouble thinking
• Vision problems
• Imbalance
Risk Factors from the consumer perspective:

• Participation
  – Divided attention
  – Walking in crowds (Community mobility)
  – Taking care of the home
  – Driving
• Environment
  – Unsuitable physical environment
    • Carpets, slippery surfaces, doorsteps
  – Climate
    • Snow, ice, heat
• Personal
  – Stress

• Nilsagård et al., 2009, Peterson et al., 2010
Summary
• Falls and injurious falls are prevalent among adults aging with disability, and begin at younger ages
• Falls occur in special contexts (like transfers) that require special training
• The consequences of falls are very serious for this population
• Risk factors include
  – Fear of falling
  – Greater mobility and aid use
  – Being middle-aged
  – Physical problems, such as poor balance, weakness, vision impairment
Levels of Prevention:
We can make a difference!

PRIMARY
Preventing falls; Decreasing fall risk factors

SECONDARY
Early detection. Working with those who are at high risk

TERTIARY
Treating those already identified, Prevent decline/deterioration
References

• Cameron MH, Thielman E, Mazumder R, Bourdette D. Predicting falls in people with multiple sclerosis: fall history is as accurate as more complex measures. Mult Scler Int. 2013.


Fall Prevention in MS

Michelle H. Cameron, MD, PT, MCR
Oregon Health & Science University
VA Portland Health Care Service

Certain slides adapted from presentations by Johanna Jonsdottir, Marcia Finlayson, and Denise Nowack
Outline

• Free From Falls – an 8-week comprehensive group education and exercise program
• Assistive Device Training for fall prevention in MS
• Multimodal Treadmill Training for fall prevention in MS
• International MS Falls Prevention Research Network
Free From Falls Curriculum

- 8-week program/2 hours per week
- Targeted to ambulatory participants
  - Unassisted or with one cane, crutch, or walking stick
- Provides awareness activities, tips, strategies, exercise
- Professionally-facilitated: physical therapist, occupational therapist, exercise specialist, others
- Program was developed with guidance from CDC and adapted from the OASIS Free From Falls program.
A Comprehensive Approach

- Addresses Fall Risks
- Fosters Fall Confidence
- Builds Better Balance
Free From Falls Program Objectives

Participants will:

• Increase their awareness of the prevalence of falls among people with MS and the risk factors that may contribute to falls.
• Identify strategies they can employ to prevent falls and develop a fall prevention action plan.
• Engage in and develop a home fitness plan that addresses balance, endurance, and strength, aimed at reducing fall risk.
• Increase their confidence in minimizing fall risk and in managing falls if they do occur.
• Identify additional community resources to implement a fall prevention action plan.
Pilot Study

- Pre, post & 6-month data assessment
- The comprehensive 8-week curriculum
- Conducted in a group setting
- One-on-one assessments with physical therapist, occupational therapist, exercise specialist and others available.

- NMSS chapters piloted the program at over 19 sites across the US.
- Data consist of 134 and 109 participants surveyed at post and at 6-months, respectively.
Post Outcomes

Significant **increase in Activities-specific Balance Confidence scale**

\[ F(1,69) = 49.52, p < .05, \eta^2 = .42 \] (see Figure 1); Increase from pre (M = 55.02; SD = 19.93) to post (M = 66.99; SD = 17.29) FFF

Significant **improvement in Berg Balance Scale**

\[ F(1,70) = 70.66, p < .05, \eta^2 = .50 \] (see Figure 2), Improvement from pre (M = 47.13; SD = 7.34) to post (M = 51.21; SD = 5.22) FFF

Significant **improvement in 8 Foot Timed Up and Go Test**

\[ F(1,81) = 14.00, p < .05, \eta^2 = .15 \], Improvement from pre (M = 11.27; SD = 4.77) to post (M = 10.18; SD = 4.21) FFF
6-Month Outcomes

- **Significant improvement in confidence** regarding falls compared to pre-program \((p < .05)\)
- **Significant decrease in concern of falling** compared to pre-program \((p < .05)\)
- **Significant decrease in activity curtailment** \((p < .05)\)
  - 35% decrease in reporting of activity curtailment due to fear of falling
- **Significant decrease in falls** in the past 6 months compared to pre \((p < .05; \text{chi square})\)
Other Findings

- 91% are more conscious of hazards & environmental risks
- 69% are engaged in regular exercise program
- 48% made modifications to their homes
- 38% are using mobility device more regularly/effectively
- Positive qualitative statements regarding program usage across physiological, behavioral & environmental domains
Complete elimination of falls is unrealistic...

...the National MS Society’s *Free From Falls* program is an effective way to improve balance, gait and the psychological impact of falls with a lasting impact in confidence and strategies for fall prevention.
Why are assistive devices associated with falls in people with MS? Conceptual models

Mengru Wang, MPH; Michelle H. Cameron, MD, PT
Attention demands → Mechanical impacts → Falls → Inappropriate device use → Metabolic demands → Assistive device use
Assistive Device Training

• Six 40-minute 1-on-1 sessions
  • Device selection and fitting
  • Training on level and unlevel surfaces
  • Training on stairs, while turning, and in small spaces
  • Dual tasking with visual and auditory distractions
Preliminary Results

From the first 8 subjects

• Significantly improved timed 25 foot walk times
• Significantly self-reported impact of MS on walking (MSWS-12)
• Reduced functional connectivity between the supplementary motor areas and the thalamus, consistent with refined inhibitory control
Effect of multi-modal intensive treadmill training for persons with MS on mobility, equilibrium, cognition and quality of life

51 persons with MS receiving usual care rehabilitation.

Active: Training on treadmill (N=28): **30 minutes 3-5X week, 12-20 sessions**. The training included aerobic work, mobility, balance and cognitive exercises in a dual tasking paradigm.

Control: Training with Wii or strength training exercises with balance components (N=23): **40 minutes 5 X week, 12-20 sessions**
### Demographics and characteristics of sample

<table>
<thead>
<tr>
<th>Demographics</th>
<th>Mean</th>
<th>Min</th>
<th>Max</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>51.8</td>
<td>27.2</td>
<td>69.8</td>
<td>9.9</td>
</tr>
<tr>
<td>Onset</td>
<td>16.6</td>
<td>0.7</td>
<td>39.1</td>
<td>9.2</td>
</tr>
<tr>
<td>EDSS</td>
<td>5.5</td>
<td>3.50</td>
<td>7</td>
<td>0.8</td>
</tr>
<tr>
<td>M/F</td>
<td>13/38</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RR/SP/PP</td>
<td>38/8/5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Falls in past year</td>
<td>2.5</td>
<td>0</td>
<td>15</td>
<td>3.5</td>
</tr>
</tbody>
</table>

- No statistical differences between groups.
Cognitive Components

- Word Fluency
- Visual exploration
- Selective attention
- Denomination
- Short term memory and autobiographical memory

Motor Components

- Motor tasks:
  - Variation of speed/inclination
  - Variation of gait requirements
  - Holding handrail or not
  - Movements of eyes, head and arms during cognitive requirements
  - Close eyes, walk backwards

Treatment

12-20 sessions, 30 minutes walking on treadmill without rest periods
3-5 times a week.

Heart rate 90-100, high effort

- MAX velocity/inclination
  - HR>100, RPE 16

3 minutes of warm up and cool down at beginning and end.
Motor and cognitive tasks while walking on the treadmill

Translation to activities of daily life!
Primary Outcome – walking endurance (2MWT)

Multimodal group: 71.4% improved walking endurance resistance
Balance/strength group (controls): 21.7% improved walking endurance

X^2 11.69  p = .0006
Both groups improved their static balance by approximately 3.5 points. Only the Multimodal group improved on TUG, a measure of more dynamic stability. The mean for the treadmill group post rehabilitation was below 14 seconds (Fall risk cutoff).
Rationale, Activities and Future

Marcia Finlayson, PhD, OT Reg (Ont), OTR
Professor and Director, School of Rehabilitation Therapy
Queen’s University, Kingston ON
Vision: International MS Falls Prevention Research Network

• Connect researchers focused on MS falls prevention
• Collaborate to develop and test multifactorial MS falls prevention interventions that build on our individual areas of expertise

• Ultimate goals:
  • Advance knowledge about MS falls prevention – pursue work we cannot do alone
  • Disseminate effective MS prevention protocols that are feasible in community-based settings worldwide.
Issues Discussed & Debated

• What can we learn from related research?
• What outcomes should we target?
  • What do we know or believe about how these outcomes come about?
• Who should we target?
• What factors should we consider during planning to maximize uptake later on?
• What would the intervention look like?
International Journal of MS Care

The Official Peer-Reviewed Publication of the Consortium of Multiple Sclerosis Centers

Falls and MS

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203 Whom to Target for Falls-Prevention Trials

ijmsc.org
What have we been doing since March 2014?

• Meeting every opportunity possible
  • Sharing resources; discussing and refining ideas; determining what is reasonable and feasible

• Intentionally and strategically working together
  • Several small initiatives to develop elements of the protocol and/or select and evaluate outcomes

• Seeking more funding to support the effort
Take homes

• Fall prevention for older adults without prior disability can be adapted for specific populations
• Adaptations depend on knowing the unique features of the specific population
• Adapted approaches need to be evaluated – you can’t just assume they’ll work
A Matter of Balance (MOB) and Low Vision or Blindness

PREPARED FOR THE NATIONAL COUNCIL ON AGING FALLS PREVENTION WEBINAR

3/3/16

John Kingston, MA COMS  John.Kingston@va.gov
Visual Impairment and Falls

- Risk factors, not just visual acuity. Loss of visual fields, contrast sensitivity & depth perception contribute to falls.
- People with visual impairment are 3 times more likely to fall if physically inactive.
- Recall of falls a problem
- 60% of falls occur in home area (backyard/garden)
- 50% of falls during negotiation obstacles (curbs and steps)
- 62% of falls occurred while walking
- 18.3% preceded by warning (dizziness/weakness)
- 2 out of 5 individuals with visual impairment fall annually

A Matter of Balance General Info

- Evidence based fall prevention program
- Runs for 8 weeks 1 x a week or for 4 weeks 2 x’s a week

Matter of Balance Sessions Involve
- Group discussion
- Problem-solving
- Skill building
- Assertiveness training
- Sharing practical solutions
- Videos
- Exercise training
- Already adapted for Low Vision
Western Blind Rehabilitation Center

1 of 13 Department of Veterans’ Affairs Inpatient Blind Rehabilitation Centers

Western Blind Rehabilitation Center (WBRC), Palo Alto Health Care System

Provides assessment and training in:

- Visual Skills
- Living Skills
- Manual Skills
- Computer Access Technology
- Orientation and Mobility (O&M)
Orientation and Mobility

- O&M teaches safe and efficient travel skills to visually impaired people, including prescribing and training with the long cane for obstacle avoidance and detection of elevation changes (fall prevention); as well as other mobility devices: walkers and support canes.
- Skills addressed may include use of other sensory systems, way-finding, public transportation, human guide skills, use of monocular telescopes, street crossing techniques for low vision and blindness, among others.
- O&M training is a pre-requisite for travelers applying to a dog guide school.
- Many O&M Specialists work in school systems, VA hospitals and State Department of Rehab.
- See resources slide for locating O&M instructors in your area.

See resources slide for locating O&M instructors in your area.
WBRC’s MOB Program

- 1st in the Department of Veterans’ Affairs to offer MOB
- 1st MOB group made of people with visual impairment (6 Veterans and 3 Coaches)
- 4 week inpatient program at Western Blind Rehab Center for Veterans with visual impairment
- MOB session occur twice a week for 4 weeks
- Daily group exercises occur after MOB session 3 where exercises are introduced
- Participants provided with descriptive audio of exercises
In addition to the MOB sessions, participants can receive 1-on-1 training from any of the blind rehabilitation skill areas.

Additionally the group participates in other events: Reacher/Grabber training, Chair Yoga, Healthy Eating Kitchen demo, Recreation Therapy events: adaptive bowling, golf, tandem bicycling, etc.

- Group aquatic therapy
- Community reintegration outings
Program Promotion

- Promotion of the program through presentations to other VA Hospitals, VA blind centers, Blind Veterans’ Association, VIST and community stakeholders.
- As well as MOB brochures, article in WBRC newsletter and social media – Facebook and Blog.

WBRC Blog at http://westernblind.blogspot.com/

WBRC Facebook Page at https://www.facebook.com/pages/Western-Blind-Rehabilitation-Center/197110680310851
Veteran Satisfaction

Veterans reported very high satisfaction with materials, activities, outings and exercises.... & encouraged us to continue the program.

- “I feel more comfortable talking about falls with my family. More aware of what I am doing and how I am doing it...”
- “I am doing the seated marching before standing up to limber me up to prevent falling”
- “The exercises were excellent...”
- “I feel better informed on the use of my walker...and on the use and value of the exercises involved in the program.”
TUG Outcomes

- Participants demonstrated an average improvement in the reduction time of -3.1 seconds on Timed Up and GO (TUG) (n=10)
- Two participants had increased time of 8 seconds
- Sometimes more time is good on TUG
- Two participants scored below TUG fall risk (13.5 seconds) on post
- TUG not normed for visually impaired
POMA Outcomes

Performance Oriented Mobility Assessment (POMA) for pre/post gait and balance assessment
- Participants demonstrated an average improvement of 2.4 points on POMA total score (n=10)
- One participant’s score remained the same on pre/post test
- One participant went from a High risk to Low risk based on POMA range (less than 19 a High Fall Risk, 19-24 Medium Fall Risk and 25-28 Low Fall Risk)
- POMA not normed for visually impaired
- Will collect data for MOB participants for comparison between traditional O&M vs MOB for TUG and POMA outcomes
Some MOB Low Vision Adaptations

- Font – Arial is easiest to read
- Size – those without a reader benefit from 18 or 20 point
- Verbal introductions at start of each session
- Have participants say their name before speaking
- Open or close doors to prevent injury
- Push chairs in
- Describe videos
- MOB provides suggested adaptations for each session to Master Trainers
While most people who are visually impaired have some vision, you shouldn't assume that your friend or relative can make out where you are and what you're doing when you are in the same room. Here are some helpful guidelines that can make communication between you more comfortable:

- When greeting a friend who is blind or visually impaired, don't forget to identify yourself. For example, "Hi, Jane, it's Sophia."
- Speak directly to your friend or relative who is visually impaired, not through an intermediary.
- Speak distinctly, using a natural conversational tone and speed. Unless the person has a hearing impairment you do not need to raise your voice.
- Address your friend or relative by name, so he will immediately know that you are talking to him rather than someone who happens to be nearby.
- As soon as a friend, relative, or stranger who is blind or visually impaired enters a room, be sure to greet the person by name. This alerts her to your presence, avoids startling her, and eliminates uncomfortable silences.

Source: http://www.afb.org/info/friends-and-family/etiquette/communicating-comfortably/235
Communicating Comfortably

- Be an active listener. Give the person opportunities to talk. Respond with questions and comments to keep the conversation going. A person who is visually impaired can’t necessarily see the look of interest on your face, so give verbal cues to let him or her know that you are actively listening.
- Always answer questions and be specific or descriptive in your responses.
- Say when you are leaving and where you are going if it is appropriate, for example, going to the kitchen to get a drink of water.
- Indicate the end of a conversation with a person who is totally blind or severely visually impaired to avoid the embarrassment of leaving the person speaking when no one is actually there.

Source: http://www.afb.org/info/friends-and-family/etiquette/communicating-comfortably/235
Tact and Courtesy

- Feel free to use words that refer to vision during the course of a conversation. Vision-oriented words such as look, see, and watching TV are a part of everyday verbal communication. The words blind and visually impaired are also acceptable in conversation.

- Be precise and thorough when you describe people, places, or things to someone who is totally blind.

- Don't leave out things or change a description because you think it is unimportant or unpleasant.

- Don’t avoid visually descriptive language. Making reference to colors, patterns, designs, and shapes is perfectly acceptable.

- When you speak about someone with a disability, refer to the person and then to the disability. For example, refer to "a person who is blind" rather than to "a blind person."

If a friend, relative, or stranger on the street is traveling with a dog guide, do not pet the dog, offer it food, or distract it in any way while it is working. Dog guides are not pets but highly trained mobility tools.

If you see someone who is blind or visually impaired about to encounter a dangerous situation, be calm and clear about warning the person. For example, if he or she is about to bump into a stanchion in a hotel lobby, calmly and clearly call out, "Wait there for a moment; there is a pole in front of you."

Do not take care of tasks for the person that he or she would normally do, such as change television channels, cut meat, or salt and pepper food. First ask if the person needs help, then offer to assist. Most people with a visual impairment will tell you if they would like some assistance.

If you are asked to complete a task for someone, always leave things in the same place you found them.

Do not move furniture or other articles in your friend’s home or your own home without letting the person know.

Resources

Department of Veterans’ Affairs Blind and Vision Services
Visual Impairment Services Team (VIST) Coordinators
VIST Coordinators are case managers who have responsibility for the coordination of services for severely disabled visually impaired Veterans and active duty Service members. VIST coordinator duties include providing and/or arranging the provision of appropriate treatment in order to enhance functioning such as making referrals to Blind Rehabilitation Centers, Blind Rehabilitation Outpatient Services and low vision clinics.
http://www.rehab.va.gov/PROSTHETICS/blindrehab/VIST.asp

Academy for Certification of Vision Rehabilitation & Education Professionals
Certifying body for O&M and Low Vision Therapists
https://www.acvrep.org/ascerteon/control/index

American Foundation for the Blind
Blindness Etiquette and Tips
http://www.afb.org/info/friends-and-family/etiquette/23

Guide Dog Foundation
Dog Guide Etiquette and Tips
http://www.guidedog.org/Content.aspx?id=1416

American Foundation for the Blind House Survey and Checklist
Questions & Answers

Type your question into the chat box on the lower left-hand side of your screen.

For reference, the recording of this webinar will be available shortly on https://vimeo.com/ncoa/.
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