**Revised-Self-Report Assessment of Functional Visual Performance**

**(R-SRAFVP)**

**Toolkit**

**Prepared by**

**Mary Warren, PhD, OTR/L SCLV**

**Deann Bayerl, MS, OTR/L, SCLV**

**Omar Mohiuddin, MS, MPH, OTR/L**

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**READ ME FIRST!**

This toolkit contains the tools needed to use the Revised Self-Report of Functional Visual Performance (R-SRAFVP) to assess and document a client’s ability to complete vision-dependent activities of daily living. You are free to use the information and forms included in the toolkit as needed to help your practice and to share them with others. We only ask that you abide by the copyright acknowledgement request for the R-SRAVFP.

***DISCLAIMER***: We are low vision professionals but we are NOT Medicare experts. All information about using the g-codes for Medicare documentation is based on our best efforts to understand the process BUT our advice won’t stand up in a court of law and your Medicare provider has the final say. If challenges arise with your Medicare provider- you must resolve your issues with them on your own!

***Copyright/Permissions***

The R-SRAFVP guide and forms are copyrighted. You have permission to freely use the assessment and forms in your practice with the following restrictions.

1. You may alter the format of the assessment form to fit your needs. This includes adding the form to an electronic medical record. You must credit the Occupational Therapy Department-University of Alabama at Birmingham as the author of the revised form.

2. You may not retitle the assessment or state or imply in anyway ownership or authorship of the R-SRAFVP assessment.

3. You may distribute the R-SRAFVP assessment to others as long as you acknowledge the authors as the source of the form.

We are interested in hearing about your experiences in using the R-SRAFVP. Please email Mary Warren at [warrenm@uab.edu](mailto:warren@uab.edu) with feedback or comments.

Thanks!

Mary Warren PhD, OTR/L, SCLV

Deann Bayerl, MS, OTR/L, SCLV

Department of Occupational Therapy

University of Alabama at Birmingham

**Introduction**

The Self-Report Assessment of Functional Visual Performance (SRAFVP) is an ADL assessment that focuses on vision-dependent ADL tasks. The original assessment was developed in 1995 as a collaborative project between the occupational therapy departments at the Eye Foundation, University of Missouri-Kansas City and Washington University with a grant from the American Occupational Therapy Foundation. The purpose was to develop a valid and reliable assessment that would provide clinically useful and quantifiable information about the ability of an older adult with age related eye disease to complete vision-dependent ADL tasks. The goal was to create an assessment that would be easy to administer and interpret and would assist the occupational therapy practitioner to develop appropriate occupation-based goals for the client.

Over time, the assessment began to show its age. Digital platforms and technologies, such as email, social media, iPods, iPads, e-readers, tablets, and smartphones were introduced after the assessment was developed and have been incorporated into older adults’ daily routines. Conversely, older adults no longer complete some of the tasks on the SRAFVP such as consulting a newspaper TV guide. Between 2014 and 2016, post-professional graduate students, Cheryl Zemina and Marlene Snow in the Occupational Therapy Department at the University of Alabama at Birmingham undertook projects to update and establish the psychometrics for a form that would more accurately reflect the activities completed by older adults in the digital age. The R-SRAFVP is the resulting product**.**

***Similarities Between the Original and R-SRAFVP***

* Both assessments focus exclusively on daily tasks that require vision to complete. As instrumental activities of daily living usually require more vision than basic ADLS the majority of items on the assessment are I-ADLs.
* Both assessments focus on the older adult with age-related eye disease including age-related macular degeneration, glaucoma and diabetic retinopathy. The data used to test the psychometrics of the assessments was collected on this population which excluded adults with stroke related vision impairment and adults younger than 60 years of age.
* It was not the intent for either assessment to provide a comprehensive assessment of the client’s ability to complete all daily activities. Instead the intent was to focus on those tasks that older adults with age-related eye disease *most often* report as being difficult to perform due to their vision loss. As older adults complete a smaller range of ADLs than younger/middle age adults, the assessments do not include some ADLs that younger adults more routinely complete such as driving, work-related tasks, yard work, and childcare.
* The process used to select the items for the assessments followed the same three step procedure. Panels of occupational therapy experts in low vision identified a set of possible items, the items were administered to a representative sample of older adults with low vision from age-related eye disease and factor analysis was used to analyze the patterns of responses from the participants to identify the key ADL constructs measured by the assessment. In each case, some items included on the initial assessment were removed because they did not correlate sufficiently with other items to describe an ADL category. The result of this process created an assessment comprised of the *key tasks* required for a client to be independent in completing the vision-dependent ADL.
* The R-SRAFVP includes six of the nine categories that comprise the original SRAFVP assessment. These categories include personal care, financial management, telephone usage, reading, writing, and functional mobility.
* The Cronbach alpha which is a measure of internal consistency within the items measured on a construct ranged from .72 to .84 with an overall Cronbach alpha of .92 for the R-SRAFVP. In comparison, the Cronbach alpha ranged from .84 to .87 with an overall Cronbach alpha of .87 on the original SRAFVP.

***Differences Between the Original and R-SRAFVP***

* The SRAFVP form contains 38 items including some items less frequently completed by older adults today such as reading a newspaper and using a paper telephone directory or television guide. The R-SRAFVP contains 33 items and includes items that reflect the older adults’ increased use of digital technology including computers, smart phones and tablets.
* Categories added to the R-SRAFVP include health management and personal preference activities and a combined category of meal/laundry preparation. The R-SRAFVP also includes a category of *personal preference activities*. These are activities that a client may or may not choose to complete. They include shaving, participating in leisure activities, operating leisure devices and reading a timepiece (e.g. watch or clock).
* A Rasch analysis was conducted on the SRAFVP to order the items in terms of the client’s difficulty in completing the item. This enables the therapist to more easily identify the “just right” challenge for the client when developing the intervention plan. The statistician on the R-SRAFVP project felt that the revised form lacked sufficient uni-dimensionality and satisfactory model fit to complete the Rasch analysis and thus the R-SRAFVP contains no ranking order for the items in each category.
* The rating scale was expanded from the three levels on the SRAFVP to five levels on the R-SRAFVP based on input from the expert occupational therapy panels who reviewed the assessment

**Test Psychometrics of the R-SRAFVP**

***Content Validity***

Content validity for the revised assessment (R-SRAFVP) was established using a 3-stage process.

Stage 1: A panel of three occupational therapy experts in low vision rehabilitation who used the SRAFVP on a regular basis were recruited to revise items on the original 38-item SRAFVP via written feedback and semi-structured interview. Suggestions and comments from the three experts were reconciled to produce the first draft of the R-SRAFVP with 59 items.

Stage 2: A separate panel of eight occupational therapy experts in low vision rehabilitation were recruited to analyze each item on the 59-item draft for item relevance. The reviewers were instructed to assign the rating based on two criteria: (a) whether ability to complete the item was important to the client’s ability to take care of themselves, live independently and safely within their home, and participate independently and safely in the community; and (b) whether the panel member frequently queried clients about performance of this item during the initial ADL assessment and addressed it in intervention because it was important in their daily lives. The panel members independently rated each item using a four-point rating scale. The context validity index (Lynn, 1986) was used to determine the percentage of agreement among the ratings of the panel members. The criterion to retain an item was set at 75% which required six of the eight experts to provide a relevance rating of 3 or 4 on the item (i.e., item-CVI ≥ .75). Using the CVI ≥ .75 criterion, the second draft of the R-SRAFVP was reduced to 50 items spread over nine categories.

Stage 3: Five older adults with low vision were recruited to provide feedback on the item clarity for the 50-item draft. The R-SRAFVP was administered to each participant and the cognitive interviewing method (Drennan, 2003) was used to evaluate the participants’ comprehension and accurate interpretation of the instrument items and rating. Cognitive interviewing confirmed that adults were able to understand the items and verified the clarity of all items on the R-SRAFVP. Pilot testing of the R-SRAFVP on the five adults provided evidence that the distribution of rating responses was consistent with the difficulty level in performing task items reported by older adults on the original SRAFVP form (Velozo et al., 2013).

***Construct Validity***

The 50-item R-SRAFVP was administered to a convenience sample of 87 older adults with low vision from age-related eye disease recruited from three low vision rehabilitation programs in three geographic regions (Florida, Oklahoma and Pennsylvania). Data was collected during a nine-month period in 2016. All of the participants resided in the community; 93% lived alone or with a spouse. Mean age was 81 years (range 60-96 years); 72% were women and 73% were Caucasian. Macular degeneration (79%) was the most prevalent reported eye disease followed by diabetic retinopathy (8%), glaucoma (1.3%) and uncorrected cataracts/corneal disease (5%). Some patients reported more than one eye condition.

Principal component analysis (PCA) factor-extraction method was used to extract the minimum number of components required to adequately describe the underlying factor structure of the R-SRAFVP. At the end of the item reduction phase, 33 items were retained and formed nine components labeled as: Personal Care (6 items), Oral Care (1 item), Meal/Laundry Preparation (6 items), Financial Management (3 items), Telephone Usage (2 items), Personal Preference Activities (4 items), Reading (3 items), Writing (4 items), and Functional Mobility (4 items). The internal consistency reliability coefficients as estimated by the Cronbach’s alpha of each component ranged from .72 to .84, with an overall Cronbach’s Alpha of .92 (95% CI = .89 to .94).

To provide additional evidence on construct validity, a known-groups method was used to support that the R-SRAFVP scale score was able to distinguish between (a) participants with mild impairment in distance visual acuity (including central or ring scotoma) and those with moderate, severe or profound impairment, and (b) participants with normal visual contrast sensitivity and those with moderate, severe or profound impairment. Parametric or non-parametric statistics were used to test the hypotheses based on data normality. Independent-samples t-tests revealed that participants with mild impairment in visual acuity (better than 20/60 or central or ring scotoma) scored significantly higher (*M* = 2.73, *SD* = .46) on the R-SRAFVP than participants with moderate to profound visual acuity impairment (*M* = 2.45, *SD* = .57), *t*(85) = 2.18, *p* = .032, Cohen's *d* = .54. R-SRAFVP scores were also significantly higher for participants with normal contrast sensitivity (*M* = 2.69, *SD* = .37) than participants with impaired contrast sensitivity (*M* = 2.47, *SD* = .60), *t*(60) = 2.03, *p =* .047, *d* = .44. Levene’s test for equality of variances indicated unequal variances and degrees of freedom were adjusted from 85 to 6.

Drennan, J. (2003). Cognitive interviewing: verbal data in the design and pretesting of

questionnaires. *Journal of Advanced Nursing, 42* (1), 57-63.

Lynn, M. R. (1986). Determination and quantification of content validity. *Nursing Research, 35*(6), 382-385.

Velozo, C. A., Warren, M., Hicks, E., & Berger, K. A. (2013). Generating clinical outputs for

self reports of visual functioning. *Optometry & Vision Science*, 90(8), 765-775. doi:10.1

097/opx.0000000000000007

**Procedures for Administering the R-SRAVFP**

The R-SRAFVP consists of two components: a self-report assessment and an optional *subjective* observational assessment of selected ADL tasks. The self-report assessment is completed first and administered as an interview with the client. If the client’s answers on the assessment suggest that he or she may be under or over estimating the ability to complete some daily tasks, items on the observational assessment that require similar visual capabilities can be used to verify the client’s responses.

1. Administer the assessment in a quiet environment free of distractions. The assessment takes approximately 20 minutes to complete.

2. Explain the rating scale to the client. You may want to prepare a “cheat sheet” with rating levels (e.g. *unable, difficult, independent…)* printed on it to remind the client of the rating scale.

3. Describe each ADL task to the client. A brief description of the components of each ADL task is included on the form. A more detailed description is included in Appendix A. Before administering the self-report assessment, familiarize yourself with the descriptors for each ADL task.

4. Instruct the client to rate his or her ability to complete the task using the rating scale. Circle the corresponding number next to the task description on the assessment form.

Circle N/A (e.g. not applicable) if the activity is not part of the client’s routine or role.

5. If there seems to be a discrepancy between the client’s rating of an item and a family member’s rating and/or the client’s functional vision, you may wish to complete the observational assessment.

6. To complete the observational assessment-select items from the list of observations that reflect the visual ability the client needs possess to complete the SRAFVP tasks that you are questioning. Observe the client complete the task(s)to confirm the accuracy of the client’s responses on the self-report assessment.

**Procedure for Manually Scoring the R-SRAFVP**

The SRAFVP provides a numerical score representing the client’s ability to complete the vision-dependent ADL tasks that are a part of his or her daily routine or role. Some clients will complete all of the tasks on the form but many clients will have never completed a task or chosen, for various reasons to no longer include a task in their ADL repertoire. To obtain an accurate assessment of the client’s ability to complete those ADLs that are relevant and important to the client’s daily living, the SRAFVP score is calculated to reflect performance only on ADL tasks that client desires to complete.

The score is expressed as a percentage of the client’s ability to complete desired ADL tasks. Expressing the score as a percentage provides a benchmark for understanding the client’s current level of independence and helps the client and OT practitioner understand how close the client is to meeting their ADL goals.

**Step 1: Calculate the Adjusted Total Possible Points.**

Determine the possible number of points that the client can earn on the form. This is a total of the number of ADL tasks that the client deems ~~as~~ applicable/desirable to daily living, multiplied by the highest possible score for each item (e.g. the highest rating for the item). Not applicable (NA) tasks are omitted from the calculation.

* Number of tasks the client completes \_\_\_\_ x 4 = \_\_\_\_ Adjusted Total possible points
* Case Study Example (Mable Moderate)
  + 1 NA item out of 33 items = 32 items completed
  + 32 x 4 = 128
  + Adjusted total = 128

**Step 2: Calculate the Client’s Total score**

* Add up the rating points for each item the client completes to calculate the total number of points he or she earned on the form.
* Case Study Example (Mable Moderate)
  + Addition of ratings for all 32 items answered = 79
  + Clients Total score = 79

**Step 3: Calculate the SRAFVP score**

* Divide the client’s total score (step 2) by the adjusted total score (step 1). This will produce a decimal score.
  + Case Study Example (Mable Moderate)
    - 79 ÷ 128 = 62 (rounded from .6171875)
    - SRAFVP score = 62% (level of independence)
* Multiply the decimal SRAFVP score by 100 and round up to the nearest full percentage score to indicate the client’s level of independence in the assessed vision-dependent ADLs
  + Case Study Example (Mable Moderate)
    - 100 – 62 = 38 which is the **Functional Score** or 38% (level of dependence)

**Procedure for Using the Calculated Spreadsheet to Score the R-SRAFVP**

The spreadsheet automatically calculates the composite score, the percentage of disability, and the G-code level. The spreadsheet has been protected & locked to prevent accidental reformatting of content and formulas. You can only enter data into the cells shaded green and blue.

**How to enter data into the spreadsheet**

* Enter the following information in the **green cells located at the top of the spreadsheet**:
  + Client’s name or MRN
  + Therapist or evaluators name
  + Assessment date; Specify whether it is an initial, progress note, or discharge assessment by deleting the other entries (e.g. to designate “Initial”, delete “Progress” and “Discharge”).
* Enter the following information **in the blue cells located in column C:**
  + Client’s ratings for the assessment items using the R-SRAFVP rating scale (note: a rating scale key is located in columns E and F for quick reference).
  + Do not leave any responses blank. The spreadsheet will assign a rating of 0 for “Unable/Dependent” for those items.

**How to interpret the spreadsheet output**

* When the rating column is completed, the embedded spreadsheet formulas automatically calculate the number of relevant measures, the composite score, the R-SRAFVP score, percentage of disability and the G-code level.
* The R-SRAFVP score, % of disability and G-code level will appear in the yellow cells located at the bottom of column C (note: a G-code key is included in columns E/F for quick reference).
* The cells will be highlighted in red for items receiving a rating of less than 3 (e.g 0-unable/dependent, 1- great difficulty, or 2- moderate difficulty) to indicate the areas to be addressed as **Goals of Treatment** in the plan of care.
* The cells will turn white for items rated as Not Applicable to indicate that these items will not be included as part of client’s score or goals of treatment to be addressed.

**How to save and print the spreadsheet**

* Save the spreadsheet as an Excel worksheet or as a PDF (see example) with the patient’s name and date.
* The spreadsheet is formatted to fit on regular 8.5” x 11” Letter sized paper without need for scaling to fit page.

**Using the R-SRAFVP for Functional Reporting (G-Codes)**

The R-SRAFVP provides advantages for assigning the correct G-code for the client.

1. G-codes are assigned based on the client’s overall level of impairment in self-care. Because the items of the SRAFVP cover a wide range of vision dependent ADLs, calculation of the R-SRAFVP percentage score will accurately reflect the required overall level of functional impairment within the primary OT category of self-care.

2. The therapist scores only those items that the client completes and adjusts the composite (e.g. total) score accordingly to calculate the percentage and assign the G-code. This is important because many older adults give up certain ADL tasks by choice. For example, a visually impaired older gentleman (let’s say my father in-law) has never cooked a day in his life and wouldn’t know a microwave oven from a toaster. Now suddenly widowed, he has chosen to eat all of his meals in the dining room of the residential facility where he lives. To accurately calculate the g-code for my father in-law, meal preparation items would be marked as “not applicable” and excluded from calculation of R-SRAFVP score.

**To Manually Determine the Associated Functional Reporting Level (G-code) modifier**

* Subtract the SRAFVP percentage score from 100 to determine the percentage of impairment for functional reporting
* Match the % of impairment for functional reporting with the correct G Code modifier (see chart)

|  |  |
| --- | --- |
| Modifier | Impairment Limitation Restriction |
| CH | 0 percent impaired, limited or restricted |
| CI | At least 1 percent but less than 20 percent impaired, limited or restricted |
| CJ | At least 20 percent but less than 40 percent impaired, limited or restricted |
| CK | At least 40 percent but less than 60 percent impaired, limited or restricted |
| CL | At least 60 percent but less than 80 percent impaired, limited or restricted |
| CM | At least 80 percent but less than 100 percent impaired, limited or restricted |
| CN | 100 percent impaired, limited or restricted |

**Supplemental Information on Functional Reporting (G-Codes)**

The information in this section is based on policies detailed in the Medicare Benefit Policy Manual (100-02) and MLN Matters: MM8005 Revised. The information reflects use of the Self-care code set, the most relevant for low vision services.

*Practitioners should always check with their jurisdiction A/B MAC to determine if additional policies have been determined for their region.* *Commercial insurance may not require, or may have a different policy for functional reporting; consult commercial insurances individually for direction*.

At evaluation

* Report G8987 and G8988, along with the related severity modifiers to report the current status and projected goal status.

Progress Report

* Report G8987 and G8988, along with the related severity modifiers to report the current status and projected goal status.

At discharge

* Report G8988 and G8989, along with the related severity modifiers to report the projected goal and discharge status.

One-Time Therapy Visit

* When a beneficiary is seen and future therapy services are either not medically indicated or are going to be furnished by another provider
* Report for the date of service:
  + G8987, G8988, G8989 (current status, goal status and discharge status) along with corresponding severity modifiers on each code line

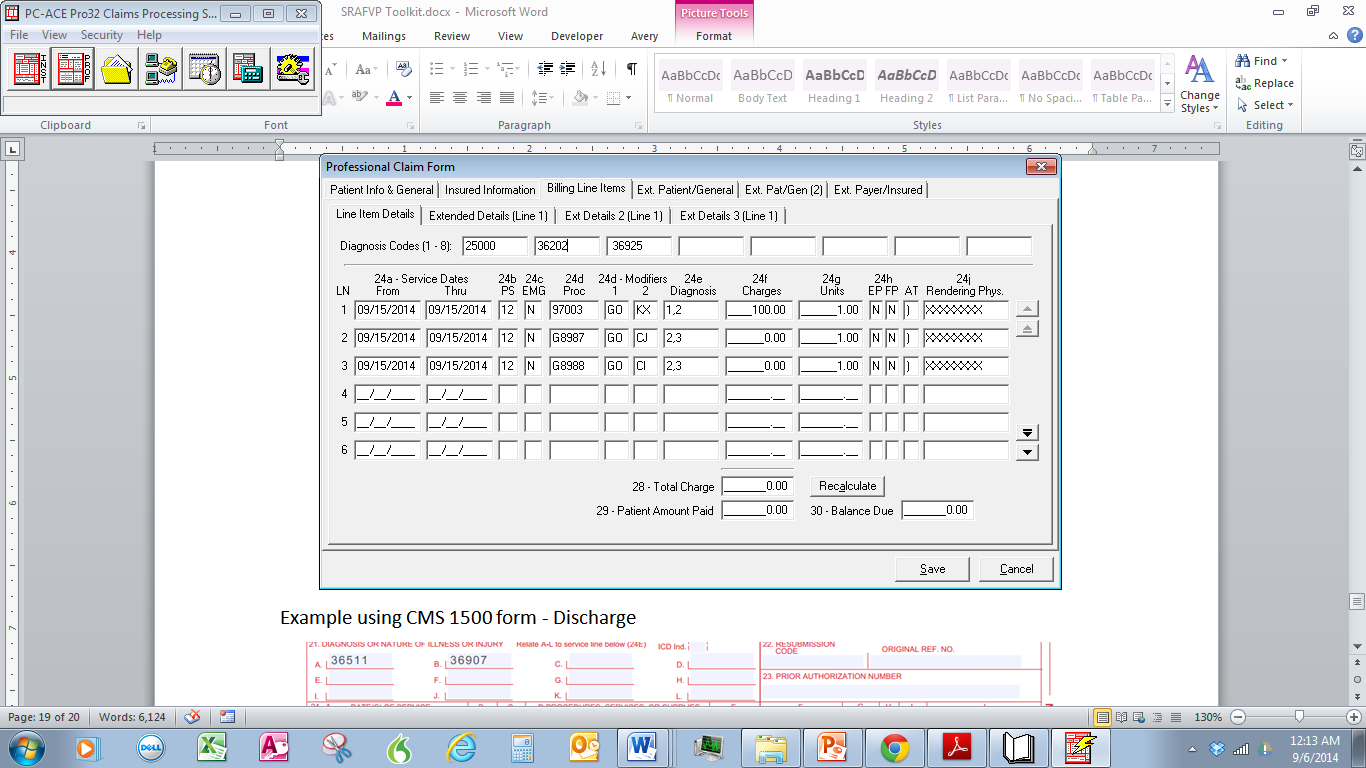
*The GO (OT) modifier must also be included on all functional code reporting lines.*

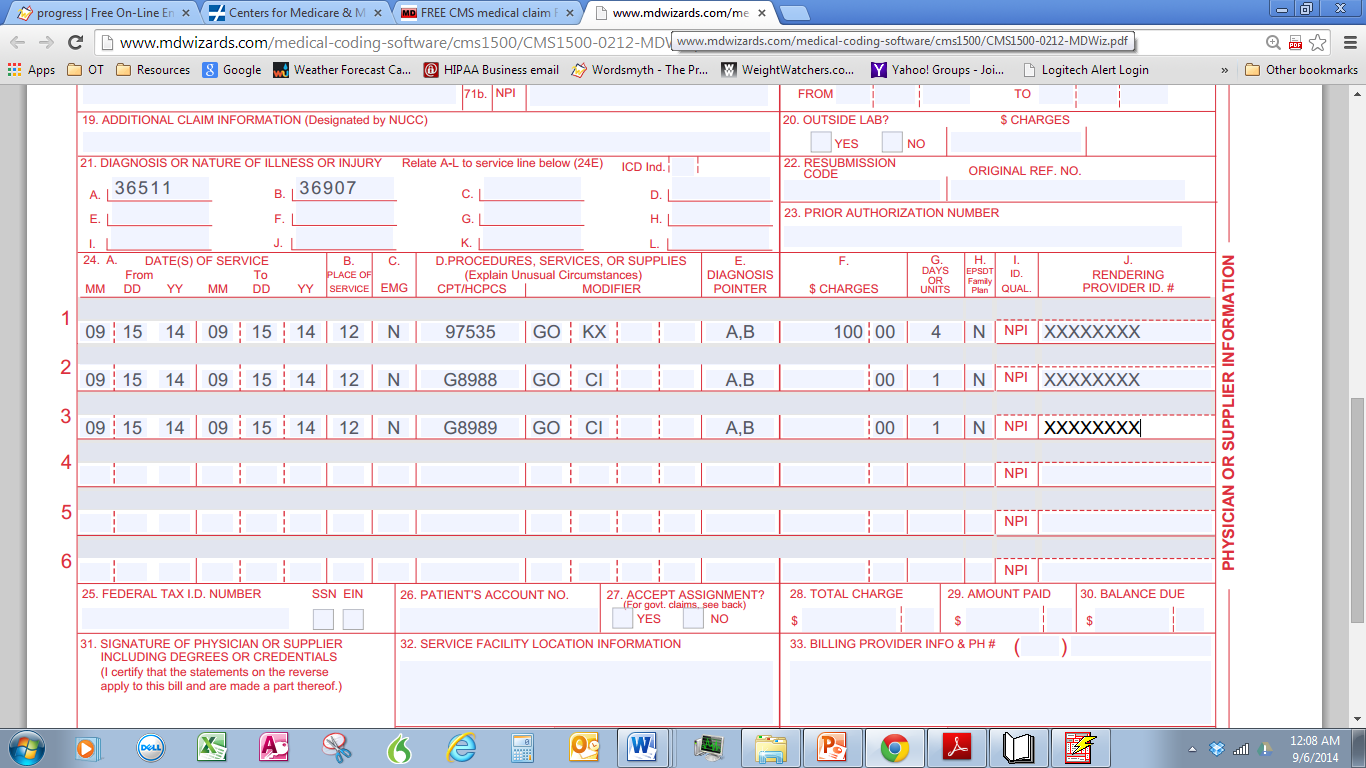
|  |  |
| --- | --- |
| **Modifier** | **Impairment Limitation Restriction** |
| **CH** | 0 % impaired, limited or restricted |
| **CI** | 1% - 19% 1 impaired, limited or restricted |
| **CJ** | 20% - 39% impaired, limited or restricted |
| **CK** | 40% - 59% impaired, limited or restricted |
| **CL** | 60% - 79% impaired, limited or restricted |
| **CM** | 80% - 99% impaired, limited or restricted |
| **CN** | 100% impaired, limited or restricted |

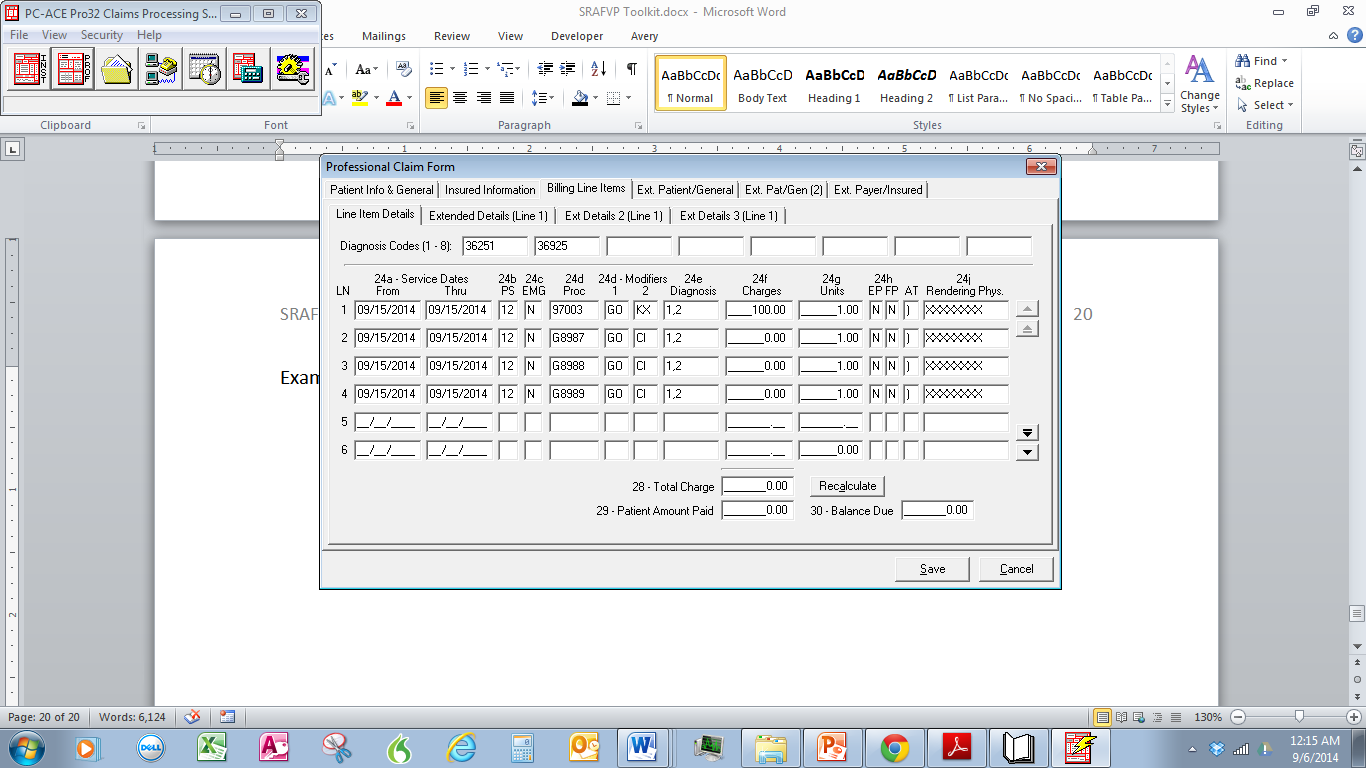
Example using CMS 1500 form - Evaluation



Example using PC-ACE Pro32 – Progress Note



Example using CMS 1500 form - Discharge

Example using PC-ACE Pro32 – One Time Visit

References

Department of Health and Human Services, Centers for Medicare & Medicaid Services. (December 21, 2012). Functional Reporting. *Medicare Benefit Policy Manual*, Chapter 15, Section 220.4, pp. 192-194. Downloadable from: <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf>