



# MAER Newsletter

Association for Education and Rehabilitation of the Blind and Visually Impaired  
Michigan Chapter

July 08, 2008

## President's Message

Dori Bordner

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The weather is changing here in the north for the better. Trees are blooming and birds are singing – some of us thought this would never get here after our record snowfall winter. Now we have more seasonal changes to look forward to... rising gas prices and those awful orange cones!!

I would like to take a brief moment to introduce our MAER Officers and Board of Directors, and Committee Chairs...

Past President – Mary Beth Kullen (Greater Detroit Agency f/t Blind & VI)

President – Dori Bordner (COOR-ISD)

President-Elect – Kathy Konow (Association for the Blind & VI)

Treasurer – Lynnette Norton (Livonia Schools)

Secretary – Roberta McCall (Michigan Commission for the Blind - Lansing)

Director – Alicia Li (Eastern Michigan University)

Director – Amanda English (Kalamazoo RESA)

Director – Erica Ihrke (Leader Dog)

Director – Jennifer Burch (Clare-Gladwin RESA)

Director – Kim Seaney (Charlevoix-Emmet ISD)

Director – Marcia Pavkovich (Genesee ISD)

Bylaws – Marcia Pavkovich, Alicia Li

Historian – Susan Bradley

Membership – Susan Bradley

Newsletter – Alicia Li

Outreach – Susan Langendonk

Scholarship – Amanda English

Well, at least we have a wonderful outlook for MAER's year ahead. We are in the planning stages for the Fall Division Day (November 7<sup>th</sup> at Genesee Intermediate School District). We will be exploring various topics at our May 30<sup>th</sup> board meeting and beginning the planning process for Division Day and the 2009 Annual Conference. We would welcome any ideas and/or assistance, if you have the time and are willing to volunteer. After the MAER 25<sup>th</sup> Annual Conference, we received a lot of ideas for what the membership

## President's Letter

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would like to see at our conferences/workshops. Anyone who wants to become involved in MAER but doesn't want to commit to an extended period of time, this is a wonderful opportunity to support MAER and receive any ACVREP credits you may need to recertify.

We are also actively working on re-establishing our Advocacy and Legislative committee. I would like to extend an invitation, on behalf of the MAER Board, to anyone interested in chairing or working on this committee. Here is a description of the committee, in case you want to volunteer to help out:

### Advocacy & Legislation

*Function:* Advocacy; Monitor state and national legislation

*Responsibilities:*

#### Advocacy

- Investigates and gather data on issues of importance to Chapter.
- Networks with other organizations on issues of importance to Chapter
- Pursues consensus building with other organizations
- Contributes articles regarding advocacy issues to MAER Newsletter & Website

#### Legislative

- Monitors pending state and national legislation
- Develops and maintains a list of Michigan's state legislators and national congressional delegation to contact as needed regarding issues and developments of interest to the Chapter
- Keeps the Board informed
- Keeps the membership informed through the MAER Newsletter & Website and at the annual conference.

*Reports to:* President and Board of Directors

Finally, we can't forget the 2008 Biannual Conference in Chicago (July 22-27). The conference begins with the MacFarland Seminar (July 22, 9:00-5:00 CT).

Training and Rehabilitation with Visual Prosthetics - As part of a wider effort to discuss these issues among the various stakeholders (rehabilitation professionals, consumers, caregivers, and manufacturers/companies) the MacFarland Seminar will stimulate a dialogue among the diverse professionals providing rehabilitation for people who would be candidates for a visual prostheses or other biotechnology therapy (e.g., gene therapy or stem cell therapy). Topics that will be discussed include: proper controls to determine efficacy of the interventions, visual function efficacy testing methodologies, evaluation of functional vision performance including evaluation of self-report PRO instruments.

The conference schedule then continues:

July 23: 9:00 – 5:00	Division Day
8:00 – 5:00	O&M Concurrent Sessions
July 24: 8:00 – 5:30	Conference Programming
July 25: 8:00 – 5:30	Conference Programming
July 26: 8:00 – 5:30	Conference Programming
July 27: 8:00 – 11:00	Conference Programming

For more detailed information visit: [www.aerbvi.org/conference/schedule.htm](http://www.aerbvi.org/conference/schedule.htm).

I'm looking forward to my two year term as your MAER President and the many new and exciting opportunities the MAER Board can bring to your professional lives. If anyone has any questions or suggestions, please contact myself or another board member. Our contact information can be found on the MAER website at [www.maerbvi.org](http://www.maerbvi.org). Be well and stay safe!

Dori C. Bordner

## From the Editor

Alicia Li

This year's MAER conference was a great success. Attendees returned home with new knowledge and strategies/tactics for working with individuals with visual impairments. Following the conference, each presenter was invited to submit a summary of his/her presentation with the hope that those

who attended would read them as an opportunity to review what they had learned and to give those not able to attend the conference a chance to "catch" the flavor of the information presented. Seven summaries were submitted for this newsletter with URLs for additional information.

## AER-Lift Leadership Conference

Dori C. Bordner

The 2008 AER-Lift Leadership Conference: *United in Our Vision* took place March 28-30, 2008 at the Omni Mandalay Hotel in Las Colinas (Dallas, TX). AER-Lift is an exciting time to "rub elbows" with AER leadership from different states and provinces. This year's conference took the form of meetings in two informational tracts – Division Leadership and Chapter Leadership. As I was the representative from Michigan, I was involved in and will report on the Chapter Leadership tract. In this tract, the group was led in discussing issues important to Chapter business, such as bylaws, budgets, board meetings, mentoring potential, chapter and division leaders, recruitment in the field, and the Chapter-Get-A-Member Program. These sessions were informational and beneficial in learning more about the organization, working within the vision of AER at the state/provincial level, and gaining leadership skills to use in one's current professional situation. The last day was devoted almost entirely to AER's Mission and the Strategic

Plan that I was privileged to work on during the 2007 AER-Lift conference. I would like to take this time to share with you AER International's Operational and Strategic Plans for the next two years (which is still a working document).

### Operational & Strategic Plan (2008-2010)

1. Improve communication, internally and externally
  - a. Improve AER's effectiveness in dealing with professional issues
  - b. Improve AER's organizational effectiveness
  - c. Provide effective legislative advocacy for the profession
2. Ensure financial stability and a balanced budget
  - a. Increase revenue per member
  - b. Increase international conference revenue

## AER-Lift Leadership Conference (cont.)

- c. Increase frequency of conferences
  - d. Increase revenue from product sales
  - e. Increase revenue from advertising
  - f. Increase revenue from professional development
  - g. Seek outside funding sources, including project grant funding
  - h. Effectively manage costs and overhead
3. Grow membership numbers significantly
    - a. Improve member benefits to draw new members
    - b. Increase number of individual members
    - c. Increase number of corporate members

The Strategic Plan goes into more detail on how AER will accomplish these operational goals over the next two years.

It has been a fascinating process to be a part of. I would like to invite anyone who would like to attend AER-Lift to do so. It usually takes place on a Saturday & Sunday in the early spring (usually before our MAER Conference) and travels throughout the United States. I was just luck this year to head to a warm location at the end of March when we were receiving an abundance of snow – the trade off of working was more welcome than all that white stuff!! If you would like to know any more about the AER-Lift Leadership conferences, please contact me.

## Eye Conditions: Retinoblastoma

Alicia Li

Retinoblastoma is a rare but life-endangering condition of childhood, occurring in one in 15,000 to 20,000 live births (Abramson & Servodidio, 1997; Boger & Petersen, 1991). Between 250 and 500 new cases are reported in the United States each year (McLeod et al., 2000). It is the most common primary malignant intraocular tumor of childhood and the second most common primary intraocular malignancy of all age groups (choroidal melanoma is more common) (Kanski,

1989). Retinoblastomas usually arise from the posterior retina, affecting one eye (unilateral) or both eyes (bilateral). Two-thirds of patients are unilateral, about 30% of cases are bilateral (Dennison & Klair, 2003; McLeod et al., 2000; Vaughan & Asbury, 1986). This condition affects all races equally. The majority (90-94%) of retinoblastoma patients have no family history of the disease; only a small percentage of patients have other family members with retinoblastoma (6-10%)

## Eye Conditions: Retinoblastoma (cont.)

(Abramson & Servodidio, 1997; Kanski, 1989). More than 90% of children with retinoblastoma in the U.S. can be cured by early detection and treatment (Abramson & Servodidio, 1997; Finger, n.d.).

### *Symptoms*

Leukocoria (white pupil) and strabismus are the most common signs of retinoblastoma. Leukocoria, sometimes referred to as a cat's eye reflex, is a white pupil reflex. Instead of a normal healthy black pupil or a red reflex seen in flash photographs, the pupil of the patient with retinoblastoma appears opaque or white (56% of cases) (McLeod et al., 2000). Leukocoria does not always indicate retinoblastoma. Other conditions can also mimic white pupils. For example, a cloudy cornea may look similar to a white pupil. Other common causes of a white pupil are as follows (Subramanian, 2008):

- Coats disease (exudative retinopathy)
- Coloboma
- Congenital cataract (may be hereditary or may result from other conditions, such as congenital rubella, ROP)
- Toxocara canis (infection caused by a parasite)
- Uveitis

Strabismus is the second most common mode in which retinoblastoma presents (20-23.6% of cases) (Kanski, 1989; McLeod et al., 2000). The child may have exotropia or esotropia. This is why fundus examination is mandatory in all cases of childhood strabismus. Occasionally, a patient with a small tumor may present with visual difficulty in the absence of strabismus (Kanski, 1989).

Other symptoms of retinoblastoma may include: secondary glaucoma (3% of cases) which may or may not be associated with buphthalmos (enlargement of the eye), poor vision (7.7%), inflammation of tissue surrounding the eye, an enlarged or dilated pupil, etc. (Abramson & Servodidio, 1997; McLeod et al., 2000; Kanski, 1989).

### *Causes and Genetics of Retinoblastoma*

Although it is not exactly understood why retinoblastoma occurs, it is known that retinoblastoma is caused by the so-called retinoblastoma gene, which is a mutation in the long arm of chromosome 13 (Aventura et al., 2006). According to McLeod et al. (2000), mutation or deletion error of the retinoblastoma gene on both copies of chromosome 13 results in retinoblastoma as well as an increased risk of other tumors, which develop later in life (e.g., osteosarcomas, fibrosarcomas, thyroid carcinomas, melanomas, etc.).

If a genetic mutation is found, there is a 45-50% chance that the parents will have another child with retinoblastoma whereas the risk of having a second child with retinoblastoma is 2-6% if there is no family history and no mutation is found (i.e., healthy parents with one affected child) (Finger, n.d.; Kanski, 1989).

Boger & Petersen (1991) stated that in sporadic cases (i.e., there is no previous family history of the tumor), those who are bilaterally affected usually present by the age of 15 months and those who have unilateral retinoblastoma by 20-30 months of age. If a parent had bilateral or unilateral retinoblastoma, his/her children may have tumors in the eye at birth or do not have tumors in the eye at birth and develop them during the first few years of life. Abramson & Servodidio (1997) indicated that tumors will begin to develop in the eyes by 28 months and can continue to form them for 7 years. It is common for children to develop retinoblastoma in one eye before it develops in the other.

### *Treatment*

To save life, preserve vision and cosmetic appearance, there are several options for the treatment of retinoblastoma (Abramson & Servodidio, 1997; Kanski, 1989):

## Eye Conditions: Retinoblastoma (cont.)

- **Enucleation:** The entire eye is surgically removed along with a long piece of optic nerve. This is usually the treatment choice for most far advanced tumors and useful vision is lost in the first eye. The management of the second eye depends on the size and location of the tumor. Approximately 3 weeks after the operation, the child is fit for a prosthesis or false eye.
- **Radiotherapy:** Radiotherapy with an external beam is preferred for medium or large tumors. The radiation treatment is performed five times per week over a 3 to 4 week stretch. Following external beam radiation, long-term effects may include cataract, radiation retinopathy (bleeding and exudates of the retina), impaired vision, and temporal bone suppression (bone on the side of the head which do not grow normally).

Although external beam irradiation could be successful in treating retinoblastoma, it has been suggested that radiation may cause an increase in the risk of developing second cancers later in life (Finger, n.d.; Wikipedia, 2008).

Local radioactive plaque is reserved for small to medium-sized tumors or for those that do not respond to external irradiation. Following the plaque, long-term effects may include cataracts, radiation retinopathy, and impaired vision.

- **Laser therapy:** This is a non-invasive treatment for retinoblastoma. Lasers are used to destroy smaller retinoblastoma tumors. Laser treatment usually does not generate post-operative pain, nor post-operative medications are required. Laser can be used alone or in addition to radiation or cryotherapy.
- **Cryotherapy (freezing therapy):** This may be useful for the treatment of small peripheral tumors. This usually needs to be

repeated many times to successfully destroy the cancer cells. Following cryotherapy, the lids and eye will swell for 1 to 5 days.

- **Chemotherapy/Chemoreduction therapy:** Chemotherapy is given intravenously to the child. The drug(s) pass through the eye via blood stream to cause the tumors to shrink within a few weeks. After chemotherapy, the child is re-examined and the remaining tumor is treated with other treatment methods such as cryotherapy, laser, or radioactive plaque.

### *Visual adaptations and other considerations*

1. As mentioned earlier, the majority of children in the U.S. survive the cancer and are able to lead normal lives. However, it is important for children with vision in only one eye to be extra careful when playing sports or engaging in some type of hazardous activities (e.g., wearing protective eye-wear during those high risk activities).
2. Children with one eye removed will have no depth perception. They need training to compensate for the lack of depth perception. By using relevant clues, such as size, distance, brightness of objects, to determine the relative distance among objects so accurate reaching can occur. Negotiating stairs and drop-offs will also improve with training.
3. The spectrum of vision resulting from retinoblastoma can range from a peripheral or central loss in one eye, even following the treatment, to bilateral peripheral, central, or total losses. Adaptations vary from individual to individual based on the scope and severity of the child's vision loss.
4. Children who have had both eyes re-

moved are usually educated utilizing the braille system. Educational considerations for students who are totally blind also apply to those with both eyes enucleated. In addition, they need to follow the instructions from their eye doctors pertaining to the use and care for the ocular prosthesis.

5. Genetic counseling is strongly recommended for individuals with retinoblastoma and their families.

6. Because of the risk of developing secondary tumors later in life, monitoring the high-risk sites of secondary tumors is recommended (McLeod et al., 2000). Common second tumors include osteogenic sarcoma, a cancerous tumor which affects the bones, and soft tissue sarcomas and cutaneous melanomas (tumors of the skin, muscle, and connective tissue).

7. The psychological burdens of a family worrying about the child developing tumors later in life could be devastating. Support groups for parents of children with retinoblastoma are critical.

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## 2008 MAER Conference Summary

### Neurology and Commonly Used Medications

Dr. Robert Shaffer

We began with a general discussion of basic neurology, which I believe is essential for all people working with people. We attempted to be more diagrammatic and schematic rather than precisely neuroanatomical and emphasize concepts and functions. One way to begin is to look at general brain geography.

It has been said that the two purposes of the brain are to preserve the individual and to preserve the species. In order to do so, one major function of lower brain centers is essentially automatic regulation of body functioning. This occurs 24 hours a day, 7 days a week and is essentially automatically. If these brain centers do not take care of business, we move up to a higher level that I term “drive based centers” including the hypothalamus and limbic systems. These areas provide motivation, often experienced as emotion, and/or drive state needs: hunger, thirst, fear, anger, etc. When activated they operate quickly but are not particularly good at thinking. When emotion or drive cannot meet our needs or solve our problems, then higher order regions such as the frontal lobes and prefrontal cortex are brought into play. Note regions in the cortical or outside area are often involved in sensory processing as well as higher order skills such as thinking and cognition. In reality, all of these levels operate simultaneously and frequently interactively.

One may consider cells as the type of building block for the brain. Traditionally, there are functional cells such as neurons and support cells “glial” cells. Learning creates a stronger network of cellular connections that allow the efficiency of either thinking, action or other functions. Cells communicate via a chemical electrical process called depolarization, which involves ionic transfer through the cell membrane with resulting chemical electrical activity. Examples of problems in cells include multiple sclerosis whereby cell transmission is impaired due to the loss of myelin or epilepsy in which cells fire almost spasmodically and uncontrollably in certain brain regions.

Much attention in the popular press and pharmacological industry is addressed toward brain chemistry, particularly neurotransmitters. There are, at last count, five minor including our old friends serotonin, epinephrine, etc., and two major (GABA). These are essential in the communication between neurons. Interestingly, many neurotransmitters are found throughout the body, a delightful book for those interested in such connections is “The Gut Brain.” Much of the modern psychopharmacology is an attempt to increase or decrease the functioning of certain neurotransmitters in order to improve health and functioning.

Sensory input is vital for human life and particularly for your work. The

outer region or cortex of the brain is divided along lines that process sensory input. For example, the posterior cortex processes visual material albeit far from the eyes. The auditory is generally processed in the left temporal or side region. Olfaction or smell operate somewhat differently and is closer in proximity to emotional and memory centers of the brain. Malfunctions in the sensory system can be caused by direct damage to these brain regions via accident, injury, or illness such as stroke, etc.

There are several types of circulatory systems in the brain. One is cerebral spinal fluid, which travels through the spinal column and flows through the ventricles or non-cellular regions of the brain. Here, occasionally, infection is found or if circulation is impaired one can have hydrocephalus in which brain tissue is compressed against the skull, often resulting in severe impairment. The second circulatory system is of course the blood supply via veins and arteries transporting nutrition or, if you will, “fuel” such as glucose and oxygen to the operating cells of the brain. An absence of nutrients such as in hypoglycemia can impair brain function as well as circulatory problems such as aneurisms or cerebral vascular accidents such as stroke when a blood cell breaks.

Detailed aspects of the lecture included some review of important structures such as the limbic system, thalamus hypothalamus, mid-brain basil ganglia, and cerebellum. I would recommend a rereading of a trustworthy text of neuroanatomy or a book that is “user friendly” discussing the detailed functions of these parts.

That being said, briefly, one could simplify the functioning by saying that input is shunted to the thalamic regions for evaluation and distribution (i.e., high threat or low threat). High threat tends to go to the emotional and drive centers such as the limbic system for immediate emotion and action whereas low threat information may be processed somewhat more leisurely in the higher centers. One can see excessive fear and anxiety from limbic over-activation as well as more specific disorders such as Kluver-Bucy Syndrome or Huntington’s Disorder with specific dysfunctions in other areas.

The conceptual and physical beauty of the brain can also be appreciated by looking briefly at other organizational principles. For example, the brain is often divided into autonomic or, if you will, “automatic” functions and voluntary functions. Interestingly, these are not totally mutually exclusive. Within the autonomic regions, there are anatomical causes that clearly differentiate the arousing effects (“sympathetic”) versus the more sedating (“parasympathetic”) regions.

I believe the brain is in some ways both simple in terms of its basic mechanisms and complex in terms of its massive interconnections and simultaneous processes. The common disorders that we deal with may sometimes have an origin in a particular part of the brain or an aspect of neurochemistry but almost invariably bring in other parts or aspects.

I.E., the disorders that we deal with can have specific chemico-anatomical origins that can sometimes be traced.



## Neurology and Commonly Used Medications (cont.)

For example, Attention Deficit Hyperactivity Disorder, Combined Form is generally thought to be related to the frontal lobe functioning, particularly the prefrontal cortex. Various problems with nutrient distribution intensity of brainwaves (beta versus alpha) or the activity of neurotransmitters (i.e., dopamine) have all been explored. Treatments reflect these theories of origin (i.e., pharmacology to improve dopamine functioning), neurobiofeedback to alter brain waves, dietary and environmental changes, as well. Another interesting case is Obsessive Compulsive Disorder (think of the movie “As Good As It Gets”). Here brain studies have found deficiencies of the neurotransmitter serotonin in the basal ganglia connecting limbic and frontal regions. These theories are well accepted but there may be a subtype (PANDAS) that could actually be caused by streptococcal infections and the toxic effects of our own autoimmune responses, at least in some individuals. The thought that some mental illnesses can be caused by infections or infective processes gone awry (either pre- or post-birth) is controversial but intriguing. Relatively common disorders such as anxiety and depression frequently involve the interplay of several brain centers, functions, and chemicals. In depression, for example, limbic over arousal with frontal understimulation has been seen along with the well-known effects of neurotransmitters such as serotonin and dopamine as well as more esoteric hormones such as Oxytocin. However, adjustments in thinking, social environment, or even exercise and diet have been effective in some cases as have a new approach called

“transcranial magnetic stimulation.” Some disorders, particularly those with a wide variety of expression usually called “spectrum disorders” are more difficult to crack. (The Autistic Spectrum Disorder is an example.)

An overview of medications perhaps too ambitious for this brief note however, is intriguing to observe that psychiatric medications are among the bestsellers in the armamentarium of the drug companies. Briefly, stimulants have been used for many decades to improve attentional functioning presumably by activating dopamine in the frontal lobes but newer medications such as Strattera operate via different chemical pathways. Newer versions of the stimulants including transdermal patches may reduce the common side effects of these medicines. Antidepressants and antipsychotics are as complex and varied as the disorders they attempt to treat. Monoamine oxidase inhibitors, tricyclics, selective serotonin reuptake inhibitors and now blends of serotonin and norepinephrine affecting agents are all popular for anti-depression, though the work with Oxytocin is also occurring.

Interestingly, anti-anxiety medications have also been used for years for sleep, fear, panic, and in different formulations for psychotic disorders. A possible consensus of the pharmacological approach is that both prescribers and consumers should be aware of the benefits and the risks as well as a sophisticated appreciation of medication’s limitations. Commonly, medications can be part of a comprehensive treatment program.

## Systematic Problem Solving

Dr. Robert Shaffer

This was intended to have two meanings: using systems to solve problems but also solving problems within a system. My subheading (somewhat tongue and cheek) is that problem-solving is fun!

The issue faced by so many of us is students with multiple problems (visual, emotional, or learning) and often within multiple systems (school, mental health, etc). Unfortunately, it may not be possible to utilize the valuable input from the audience for this brief summary. As a rule, I enjoy utilizing a case study approach to study problem solving. Sometimes, the least successful cases have as much to teach us as the most successful. I particularly recommend this in a staffing context where cases can be shared. That being said, there are a number of fairly standard approaches that could be explored in more detail if interested.

One of the oldest is the Socratic Method going back to, of course, Socrates as revealed by Plato. In a manner of speaking, this is a series of selected questions we ask either of ourselves or of others in order to find the truth. Examples might include the question "Whose problem is this?" The answer to that question may tell you who will work the hardest to solve it! A sub-genre of the Socratic Method is the point-of-view approach in which we systematically explore, with great honesty, the point of view of each member involved in the problem: staff, family, student, etc.

A third and perhaps the most popular approach is derisively called "the cookbook approach" in which an authority outlines a semi-rigid, step-by-step approach to any number of problems. This is becoming more common as treatment is being standardized.

There are advantages and disadvantages with this strategy. On the positive side, there may be an increased uniformity of treatment which can be good if the original treatment proposed was inadequate. Obviously, there will be greater consistency from facility-to-facility in the hope that fewer numbers will be underserved. On the downside, this approach may stifle creativity and be too simple for complex or multiphase problems. By analogy, every McDonald's hamburger across the country tastes the same; but it's still a McDonald's hamburger.

More sophisticated approaches include decision tree approaches utilizing logic and requiring somewhat more space than we have available. Some strategies that I think that are worthy of consideration are data collection approaches in which we utilize objective material to evaluate success and track over time. Client-activated approaches in which progressively greater responsibility is given to the student and family, and one of my favorites, the book "Getting to Yes" by Fisher, Ury and Baton from the Harvard Business School. I believe that group had a follow-up book called "Difficult Discussions," if memory serves.



## MDE-LIO is on the Move Again in Providing Excellent Programming and Services in Michigan

Collete Bauman

The current MDE-LIO program was previously known as Michigan School for the Blind-Low Incidence Outreach. MDE-LIO staff provides outreach services to all LEA's, PSA's, ISD's, children with a visual impairment, students who are deaf/hard of hearing and their families, as well as other resource agencies.

The overarching goal is to provide technical assistance and resources to enable local service providers to serve and improve the quality of education for students with a visual impairment or those who are deaf/hard of hearing including those with multiple impairments.

### Highlights of the year:

- Braille and large print books provided to students across the state prior to school starting!
- Addition of an Orientation and Mobility Task Force Team
- Increase in participation in regional class offerings statewide
- Additional ISD's signed up for the Independent Living Skills Pilot Program
- The number of Sign Language Proficiency Interviews increased
- "The View" was introduced online to provide easy access to books held in the LIO library
- Persons who took technology or ILS classes were now eligible to be participants in a newly developed listserv to answer their specific needs
- A statewide conference was held to provide information regarding teaching higher math skills for students with a visual impairment
- "R and R" for Supervisors of Programs for Students with a Visual Impairment was held
- Collaboration with Lenawee ISD to provide an Interpreter's workshop
- Collaboration with MAER MI Association Education and Rehabilitation for the Blind and Visually Impaired to provide a nationally known speaker for students, their families and professionals in the field of visual impairment in Michigan
- Two years of data has been recorded and provided regarding students taking the MEAP and MI-Access

For additional information please go to our website at <http://www.cenmi.org/msdb-lio>.

## O & M Severity Rating Scale

Susan Langendonk and Susan Bradley

The Michigan O&M Severity Rating Scale (OMSRS) is in the process of being revised. At the 2007 MAER conference, suggestions for revisions were made by those in attendance. An Orientation and Mobility Task Force was formed during the 2007-2008 school year and met twice at MDE-LIO. A focus of this group was to incorporate the suggestions from the conference, continue with the revision and present a draft of a new scale at this year's MAER conference.

An online survey designed to determine the use and efficiency of the OMSRS was developed by the Task Force and posted on the Michigan VI Listserv in March for input from the profession. Results were shared during the session on the OMSRS at the 2008 conference. Of those who responded to the survey, 79% used or had used the OMSRS. When asked how well overall the SRS was in determining or validating service time, 88% said it was somewhat or very useful.

A draft of the revision was shared during the working part of the session. Suggestions for wording, the way the scale could be scored, and point values were discussed. It was suggested that there is a need for research based data to verify what constitutes age appropri-

ate levels of skills. The O&M Task Force will meet to continue the revision based on the suggested changes. Additional professionals who volunteered during the conference session to work on the project and the Task Force met again in May. At this work session, it was decided that the scale worked best when divided into two separate scales: one for students whose primary impairment is visual and a new scale for students who are visually impaired with additional impairments.

One of the suggestions from the 2007 conference session was that some factors that affect a student's need for instruction should receive more points than others. This question was included in the March survey and nearly all factors were chosen as needing to carry more weight. The Task Force decided not to attempt to change this in this revision.

The Task Force is currently testing the scales to determine whether they accurately predict the appropriate level of service. The Task Force will discuss how and when to present a draft of the revised OMSRS to the membership.



## Stepping Stones: Leader Dog GPS Field Exercises

Erca S. Ihrke and Meredith Newhouse

Stepping Stones: Leader Dog GPS Field Exercises presentation focused on the five and a half day Leader Dogs for the Blind GPS training course. The theme of the training course was “Where am I? Where do I want to go? How am I going to get there? (WWH).” WWH applies to the software orientation and navigating the environment.

The field exercises have been developed and tested in a variety of environments to provide situational results and to set-up teachable moments. Field exercises start in a home-base area, and then extend to quiet residential areas.

Over the course, a variety of environments are introduced with increasing complexity in traffic and navigational skills. Objectives in lessons also increase in complexity. Field exercise lessons include creating points of interest (POIs), segment identification, creating “quick” routes, creating point-to-point routes, navigating areas away from streets, and drop off exercises.

The integral part of working with and teaching GPS is for instructors to test environments and new environments so that one is prepared for what might happen and what the teachable moments for that environment will be.

## The Truth About Diabetes and its Complications

Debra Sokol-McKay

*(Editor’s note:* Ms. Sokol-McKay did not write summaries of her presentations, but sent resources pertaining to the topics she presented at the conference.)

a. “Myths and Complications of Diabetes:” Please refer to Ms. Sokol-McKay’s article, “Dispelling the Myths about Diabetes,” in the recent edition of AER Report (Vol. 25, No. 1, pp. 1 & 30).

b. Links to RT News:

[Non-Visual Insulin Measurement Tools and Techniques, September 2007](#)

[Insulin Identification and Visual Measurement in RT News](#)

[March 2007](#)

[Insulin Management – the Basics in RT News Dec. 2006](#)

[Non-Visual Techniques for Blood Glucose Monitors in RT News Sept. 2006](#)

[Blood Glucose Monitors with Speech Capacity in RT News June 2006](#)

[How to Choose a Low Vision Blood Glucose Monitor in RT News Mar 2006](#)

[The VRT’s Role in Blood Glucose Monitoring - RT News Dec. 2005](#)

[What Rehabilitation Teachers should know - Chronic Complications of Diabetes - Aug 2005](#)

[Hypoglycemia - What Every CVRT](#)



## The Truth About Diabetes and its Complications (cont.)

[Should Know RT News Sept. 2004](#)

[Dispelling Myths about Diabetes - RT News - June 2004](#)

[Rehabilitation Teaching and Diabetes Management - RT News Mar 2004](#)

[www.visionaware.org](http://www.visionaware.org)

This is an extensive soup-to-nuts discussion on diabetes, including numerous hyperlinks, and was designed both for consumers and professionals.

The March 2007 edition: This is a special issue on macular degeneration authored by Dr. Lylas Mogk, a leader in the field of low vision optometry.

The September 2007 edition:

## Assessing Vision of Infants and Children with and without Special Needs, Including Cerebral Visual Impairments

**Kathleen Appleby**

**FOR HANDOUTS GO TO:**

**[www.visionkits.com](http://www.visionkits.com)**

**VISUAL FUNCTION**

**TYPICAL VISUAL DEVELOPMENT**

**DORSAL STREAM - WHERE SYSTEM**

**VISUAL CORTEX**

**VENTRAL STREAM - WHAT SYSTEM**

**SOME CAUSES OF CVI**

**PROGNOSIS FOR RECOVERY**

**SEQUENCE OF VISION ASSESSMENT**

**WHAT EFFECTS RECOVERY?**

## Minutes Summary from May 30, 2008 Board Meeting

Roberta McCall, CVRT, MAER Secretary

The mission of MAER is "To render all possible assistance to the promotion, development and improvement of all phases of education and rehabilitation of blind and visually impaired persons of all ages." Your Board works hard throughout the year to bring you a high-quality annual conference, as well as managing other business that comes before it.

Here is a brief summary of the last Board meeting held on Friday, May 30, 2008.

This year's conference proved a great success with 127 people attending and 24 vendors. There were many positive comments about the "new look" of the conference, the layout of vendors, use of a punch card as incentive for members to talk with vendors, and the change in door prizes. The conference cost this year was \$27377.03, which resulted in a \$5374.53 deficit. We attempt to keep conference registration cost low and to bring in nationally known speakers.

**MARK YOUR CALENDAR!!** Division Day will be held on November 7,

2008 from 8:30 am to 3 pm. at Genesee ISD. The theme is "Focus on the Safety of the Professional in Today's World". We are hoping to have a hands-on self-defense training, swap meet, and other presentations.

The 2009 MAER conference will be held on April 23-24, 2009 at the Marriott at Laurel Park. The theme has not been determined, but we are working on inviting nationally recognized speakers as well as those among you. Watch for the "Call for Papers" this fall.

The Board voted to establish the Communications Committee which will be responsible for electronic communications, such as maintaining our website, electronic newsletter distribution, etc. Susan Langendonk was appointed to chair this committee.

The next meeting of the MAER Board is scheduled for September 22, 2008 from 10 a.m. to 2 p.m. at the Ingham ISD in room 411 of the Thorburn Education building. Contact any member of the Board for more information.

## Bulletin Board

1. Mark your calendar for MAER Division Day: Friday, November 7, 2008. This year's topic is "**Focus on the Safety of the Professional in Today's World.**" This event will be held in Genesee Intermediate School District (2413 W. Maple Ave. Flint, MI 48507-3493). More information will be available in September.
2. Nominations SOUGHT For AWARDS: The MAER Board is seeking nominations for either of our two awards to be presented at our 26th annual conference which will be held on April 23 and 24, 2009. The awards and criteria are copied below from MAER's Board manual. We would like to determine our award winners far enough ahead to allow plenty of planning time.

Please contact Roberta McCall 517-333-5276 or [mccallr@michigan.gov](mailto:mccallr@michigan.gov) with your nomination.

### *Awards and Recognition*

#### **MAER AWARD**

*The MAER Award shall be given to an individual(s) or organization(s) who has made a significant contribution to the field of blindness and/or in the service of blind and visually impaired persons in Michigan.*

#### **DAVID AND JOANN SEARCH Lifetime Achievement Award**

*The Lifetime Achievement Award shall be given to an individual(s) at the annual conference who has recently retired or who is about to retire. The candidate(s) shall have demonstrated a lifelong dedication to serving blind and visually impaired persons in Michigan."*