BEST PRACTICES

in the Administration of the OIB Program

May 2018

OIB TAC
Older Individuals who are Blind
Technical Assistance Center
WWW.OIB-TAC.ORG

Introduction

Dear Colleagues,

In recent years, there has been an increased emphasis and interest in providing services to older adults based on best known practices.

This document details best practices associated with services to older individuals who are blind, developed by a panel of experts. It is intended to be a guide to policy makers, service providers, and administrators in their efforts to provide quality services through OIB programs. The best practice may be a standard that challenges some state programs. Acceptable practice includes a plan to move toward the best practice, and the unacceptable practice is typically regarded as unsafe, detrimental, or nonproductive in assisting OIB consumers become as independent as possible.

We hope this presentation of best practices will stimulate a national discussion about OIB services. There was lively discussion and, at times, some very rigorous disagreement among panel members before consensus was reached regarding these guidelines. Drafts were recirculated until all participants were willing to endorse the final documents.

We are thankful for each person who generously contributed their time, expertise, and opinions to be a part of the expert panel and to the OIB-TAC staff and contractors involved in the process. We believe this represents a significant step toward developing collaborative national standards of practice that reflects a degree of professionalism that is much needed in the OIB program.

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Older Individuals who are Blind Technical Assistance Center. (2018). *Best practices in administration of the OIB program*. National Research and Training Center on Blindness and Low Vision, Mississippi State University.

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Older Individuals who are Blind Services

Independent Living for Older Individuals who are Blind (OIB) programs are operated by state vocational rehabilitation agencies and are funded by the Rehabilitation Services Administration, Office of Special Education and Rehabilitation Services, U.S. Department of Education. OIB programs provide support for persons 55 years of age or older with severe visual impairments who need rehabilitation services to address their independent living goals but for whom competitive employment is extremely difficult. Funding is also used to improve the public's understanding of the challenges associated with vision loss and for activities that improve or expand services to the target population.

Older Individuals who are Blind (OIB) Training and Technical Assistance Center

The Older Individuals who are Blind Training and Technical Assistance Center (OIB-TAC), funded by the Rehabilitation Services Administration (RSA) (#H177Z150003), is housed at The National Research and Training Center on Blindness and Low Vision at Mississippi State University. The OIB-TAC provides training and technical assistance to improve the administration, operation, and performance of OIB programs operated through designated state agencies (DSAs). Training and technical assistance activities address four major areas: best practice; community outreach; financial and administrative management; and program performance, including data reporting and analysis. The American Foundation for the Blind (AFB), the Helen Keller National Center for Deaf-Blind Youths and Adults (HKNC), Hadley Institute for the Blind, and VisionServe Alliance have served as partners to the OIB-TAC in this project.

Addressing Best Practices

Given the charge from RSA to the OIB-TAC to provide training and technical assistance in best practice, OIB-TAC staff attempted to identify best practices for OIB programs. Best practices are typically derived from existing research and professional literature. However, there is a lack of evidence-based research identifying effective operations for OIB programs. Many service providers appear to rely on agency-based training or their shared experiences to guide service delivery and program operation, particularly when services are provided by persons without professional licensure or certification.

The OIB-TAC staff developed the following definition of best practices:

> *Best practices are service delivery strategies or techniques that appear effective based on available evidence; are client-centered; are sensitive to the context of the service delivery setting; and are responsive to evolving technology, resources, and/or research (OIB-TAC, 2017).*

Based upon their experience, knowledge, expertise, and the training and technical assistance provided to state OIB programs, the OIB-TAC staff generated a list of topics where OIB programs are in particular need of guidance regarding best practices. Using recommendations for making the link between practice and scientific evidence (Coulter, Elfenbaum, Jain, & Jonas, 2016), the OIB-TAC staff identified, convened, and worked collaboratively with the Best Practices Task Force, referred to as the expert panel, to develop best practice guidelines for OIB programs.

Expert Panel

OIB-TAC staff identified content experts with professional knowledge, histories working with older individuals with vision loss, and availability to participate in an expert panel. The panel included at least one of each of the following: low vision therapist, certified orientation and mobility specialist, and occupational therapist. Panelists were from private and state OIB programs and included seven former or current OIB program managers and two state OIB program directors. Panelists espoused diverse philosophical approaches, included persons who were blind or had low vision, and represented urban and rural areas. Please see the appendix for additional information about members of the expert panel and their professional credentials.

Procedure

Expert panel members reviewed the definition of best practice and goals for the meeting. An overview of the process for generating best practice guidelines, which was a modified Delphi procedure (Coulter, Elfenbaum, Jain, & Jonas, 2016), was discussed and rehearsed. Panelists were asked to reach a consensus about best practice guidelines for topic areas.

The team was divided in half and each group reviewed a list of different topics concerning OIB administrative management, finding and developing quality OIB personnel, or implementing an effective OIB program. One group was tasked with generating best practice guidelines concerning administrative structures of OIB programs, OIB program evaluation, effective use of advisory councils, roles of occupational therapists, staff recruitment and retention strategies, staff qualifications, staff education and continuing education, and roles of paraprofessionals. The other group addressed prioritizing OIB services, consumer eligibility, prioritizing consumers, managing costs of devices and assistive technology, prioritizing provision of assistive technology, cultural competence, community outreach, and roles of paraprofessionals.

Groups then divided into two sub-groups, each with its own facilitator and note taker. After discussing assigned content areas and generating drafts of best practices for each area, the sub-groups reconvened. The small groups discussed each topic until it reached a consensus about best, acceptable, and unacceptable practices for each topic. The groups then reunited, with each smaller group presenting its draft of best practices for the topics on their list. Each topic was discussed and copious notes taken about various perspectives of the experts.

Two content experts were unexpectedly unable to attend the panel meeting but did participate in document review and refinement.

Document Development

The expert panel spent two days discussing and developing drafts of best practice documents. OIB-TAC staff used the drafts and notes from expert panel meetings to refine the best practice documents for each of the topic areas. Each content expert then had the opportunity to review edited drafts from two to four times. Feedback from the expert panel members was incorporated into the documents at each point. The two content experts unable to attend the panel discussions reviewed and provided substantive content to the best practice documents. Each expert had the opportunity to review the final document before its dissemination. Consequently, this document carries the endorsement of each of the persons who participated in its development.

This document will be revised, as needed, pending emerging research and feedback from professionals in the field. This document is not comprehensive, in that there are additional areas in OIB service delivery and program management that are not addressed. Readers are encouraged to use the OIB-TAC Community of Practice, located on the OIB-TAC website, to discuss the best practices in this document, to suggest additional areas for future study, and to use this document as a tool to assist in improving program services to older adults.

Coulter, I., Elfenbaum, P., Jain, S., & Jonas, W. (2016). SEaRCH expert panel process: Streamlining the link between evidence and practice. *BMC Research Notes*, 9-16. Retrieved from: https://doi.org/10.1186/s13104-015-1802-8.

ADMINISTRATIVE MANAGEMENT

Program Management

Best Practices

The manager of the state OIB program must have the leadership and administrative skills to oversee the OIB program and maintain rigorous control over all aspects of service delivery, including the ability to recognize and support qualified staff. The program manager will develop, in conjunction with designated stakeholders, a strategic plan that includes short and long-term programmatic goals, timelines for service implementation, and procedures for program evaluation. The program manager will ensure that service providers, whether employed by the agency or by contract, are appropriately licensed or certified, have clear deliverables with appropriate timelines, and adhere to a quality assurance process.

The program manager will ensure compliance with all federal guidelines for the program, support program evaluation, and engage in activities to promote quality service delivery. The program manager will attend the annual OIB program managers meeting.

When direct services are provided (beyond information and referral), regardless of service delivery model, the program manager will ensure that service providers conduct functional assessments and develop individual service plans, with consumer input, consistent with issues identified by the assessment.

The program manager will ensure that individual staff training plans are developed and that those plans address individual or programmatic goals and support staff licensure or certification. Agency resources will support development activities for staff to obtain or maintain appropriate licensure/certification.

The program manager will ensure that staff refer consumers who indicate an interest in or respond positively to suggestions about potential employment to VR counselors trained to assess and work with older consumers.

Acceptable Practices

Any agency that does not implement best practices will have a plan in place to move toward best practices that includes an expeditious timetable and benchmarks.

Unacceptable Practices

When there is no plan to move toward best practices, or when that plan is not executed in a timely manner, the practice is unacceptable. Failure to adhere to federal guidelines, maintain appropriate oversight of contracted services, or facilitate service delivery by qualified personnel are also unacceptable.

Clarifying Comments

State agencies may provide services directly, through contracts with private providers, or by using a combination of service delivery systems. State program directors oversee delivery of qualified services and ensure compliance with federal regulations regardless of service delivery model. Program managers are encouraged to use available resources for training and technical assistance for administrative and direct service personnel.

Program Evaluation

Best Practices

The OIB program manager will oversee an annual program evaluation that includes multiple measures of program efficiency and effectiveness. Evaluation measures may include a combination of file reviews, feedback from an advisory board, consumer input, empirical measures of consumer progress and outcomes, assessment of staff development and competencies, review of expenditures, programmatic outcome measures, agency procedures and records, and input from staff. Evaluations will include a description of how the agency used information from the previous program evaluation to make improvements in service delivery and/or its administration.

Program directors will conduct or obtain evaluations on an ongoing basis to monitor the program and promote quality service delivery. The program manager will work with administrators, staff, consumers, contractors, and other stakeholders, as appropriate, to collect information about consumer characteristics, outcomes, and satisfaction; services provided; referral sources; programmatic activities; service delivery methods; program governance; communication methods; staff characteristics and competencies; and financial management.

Program managers will use information from program evaluations to devise or revise programmatic goals and objectives and establish benchmarks for progress to promote effective and efficient service delivery.

Contracts with external vendors must include provisions for the contractor to collect and report specified data so that the program manager can monitor and evaluate the contractor's performance and compliance with programmatic goals and procedures.

Acceptable Practices

Any agency that does not implement best practices will have a plan in place to move toward best practices that includes an expeditious timetable and benchmarks.

Unacceptable Practices

It is unacceptable to rely solely or primarily on measures of consumer satisfaction for program evaluation purposes, rather than using multiple assessment measures that include consumer outcomes.

Clarifying Comments

An outcome based program evaluation, also known as a summative evaluation, determines if the program is meeting its established goals. Process evaluations, or formative evaluations, assess progress of ongoing programs and provide staff with feedback regarding opportunities for improving service delivery, including what is and is not working and why. Outcome and process evaluation methods can be combined to generate a comprehensive program evaluation.

Program evaluation can confirm delivery of effective services and identify areas for improvement. Internal and external evaluations contribute to service delivery effectiveness and

efficiency and in generating goals. Depending upon the agency's strengths and areas of concern, the program evaluation may focus on specific programmatic components.

Consider using a logic model to facilitate a critical evaluation of the OIB program. A logic model can be a tool to (a) generate alternative strategies to improve outcomes, (b) clarify outcomes, (c) improve communication about the process and outcomes, and (d) provide a focus for linking program components. Logic models identify inputs (programmatic resources), activities (actions and tasks), outputs (countable products), and client outcomes (changes or accomplishments) that describe how a program works. For more information, a Logic Model Development Guide is available from the W.K. Kellogg Foundation.

Program directors are encouraged to conduct quarterly file reviews on a sample of open cases to assess progress toward programmatic goals. Program evaluation plans, results, and response to results will be presented to and discussed with the advisory board and other stakeholders.

Advisory Boards

Best Practices

Consumer and stakeholder feedback is vital to the effective implementation of the OIB program. Multiple methods will be used to obtain that feedback, including advisory boards comprised of representatives from identified stakeholder groups, such as consumers; community partners; consumers' family members; and persons with specialized knowledge about community resources, aging, or vision loss. An advisory board specific to OIB is encouraged.

The advisory board will have a clearly defined mission and purpose and will participate in the quality assurance process. Members will have defined roles and terms of service, and a plan for appointing members and voting will be in place.

The OIB staff will educate the advisory board members about the program and its funding sources and requirements. The OIB program manager will facilitate exposure to the staff, consumers, and, where applicable, to facilities. The OIB program manager will report program evaluation results to the board and give feedback about how input from the board is used. Advisory board members will receive specific information about current and proposed programmatic goals and objectives and give feedback to the program about its strategic plan.

The OIB staff will facilitate the advisory board activities, as needed. The OIB staff will arrange a meeting place and transportation support for members. OIB staff will assist in identifying and securing training for board members about confidentiality issues, identifying and addressing potential conflicts of interest, and developing a code of ethics for board members. OIB staff will provide assistance, as needed, to develop an agenda, take and distribute minutes from the meetings, and devise action plans. Boards will meet at least twice each year.

Acceptable Practices

Any agency that does not implement best practices will have a plan in place to move toward best practices that includes an expeditious timetable and benchmarks.

Unacceptable Practices

It is unacceptable to ignore feedback from the advisory board. It is unacceptable to withhold information from the advisory board regarding program evaluation outcomes, progress toward meeting goals, or major factors or changes influencing the program.

Clarifying Comments

Some advisory boards serve as liaisons with consumers. When boards provide this service, consumers must have a mechanism to communicate with board members. OIB-specific advisory boards are valuable for obtaining consumer feedback. However, OIB advisory boards should only be utilized when the OIB program is committed to providing the board with necessary education and support.

Occupational Therapy

Best Practices

Occupational therapists (OT) must have a license to provide services, as well as certification or training in low vision. OTs must document their competence providing services to seniors with low vision. Vision rehabilitation professionals and OTs will work together, each within their areas of expertise, to provide comprehensive services. OTs will typically work with seniors with low vision rather than persons who are blind.

Acceptable Practices

Any agency that does not implement best practices will have a plan in place to move toward best practices that includes an expeditious timetable and benchmarks.

Unacceptable Practices

It is unacceptable to fail to recognize the important service that OTs can provide older consumers with low vision or to fail to work collaboratively with OTs when they are providing services. It is unacceptable to utilize the services of an OT for vision rehabilitation services when the OT does not have documented specialized training to work with older adults with vision loss.

Clarifying Comments

OIB programs vary in their employment or use of OT services and providers. OTs, as with other professionals, should provide services only within their areas of expertise. Expertise can be documented via appropriate licensures and certification, behavioral observation, letters of reference, and/or participation in appropriate continuing education opportunities. Vision specialty OT services may be covered by medical insurance plans, including Medicare, which require a physician's referral. OIB staff may suggest that consumers pursue a doctor's referral to an OT with vision specialty, as appropriate. OTs will refer to other professionals, as needed, to meet other rehabilitation needs, such as orientation and mobility training.

IMPLEMENTING AN EFFECTIVE PROGRAM

Service Delivery

Best Practices

Quality intake services are critical to identifying consumer needs so that intake workers can refer consumers for assessment by the appropriate discipline-specific provider. A discipline-specific qualified professional (CVRT, COMS, NOMC, OT, CRC, CLVT, etc.) will conduct a thorough assessment, recommend and/or provide specialized services, and suggest additional referrals, as appropriate. Individual consumer services will be prioritized based on professional assessments.

In a resource-constricted environment, the primary service will be information and referral. Everyone in the agency will be able to provide basic information and referral services. Staff will refer consumers who indicate an interest in or respond positively to suggestions about potential employment to VR counselors trained to assess and work with older consumers. Agency staff will contact the state deafblind coordinator or the Helen Keller National Center for Deaf-Blind Youths and Adults regional representative when consumers have dual sensory impairment (deafblind).

OIB staff will inform consumers about the clinical services and devices available in the marketplace, regardless of whether or not the program can provide those services or devices. The program manager will ensure that a resource list, which includes local, state, and national resources to help adjust to and cope with vision loss, is readily available in various formats to meet consumer needs.

Acceptable Practices

Acceptable practices always include a plan to achieve best practices, including benchmarks and timelines. When necessary services are not available, the agency must provide appropriate information and referral.

Unacceptable Practices

It is unacceptable to put consumers at risk due to lack of services. It is unacceptable to fail to provide appropriate information and referral services. It is unacceptable for unqualified personnel to provide services. It is unacceptable to provide services that are not based on individualized consumer functional assessments.

Clarifying Comments

Each state is unique in its organizational structure and available resources. As states strive to meet needs within the constraints of their service delivery systems, each must focus on reducing consumer risk and fear, while improving safety and quality of life. Not all programs provide the full array of services allowable under the current legislation. For example, many states do not provide surgical or therapeutic treatment or hospitalization.

Services must be individualized and prioritized based on consumer needs identified by assessment. Provision of services should not exceed the expertise of the service providers. For example, Low Vision assessments should be completed in a clinical setting by a qualified eye care provider with expertise and experience in low vision. When a qualified eye care provider is not available to conduct low vision assessments, only devices and services

within the scope of expertise of the professional should be provided, and the consumers informed of options for additional services.

If local community resources are not available, every effort should be made to develop services to meet the needs of the consumers.

Consumer Eligibility

Best Practices

State eligibility requirements must be consistent with national legislation, which defines an older individual who is blind as an individual age 55 or older whose severe visual impairment makes competitive employment extremely difficult to obtain but for whom independent living (IL) goals are feasible [CFR Title 34, Part 367, Subpart A.5.(9)].

Visual eligibility is based upon (1) a severe visual impairment defined as a distance visual acuity of 20/70 (or 40 degrees remaining field or worse) –OR– (2) a functional vision assessment by a qualified professional. A current eye report will document level of vision.

If a consumer cannot afford an eye exam, the agency will assist the consumer in accessing Medicaid or Medicare and exploring other potential community resources. When other options are not available, the agency may pay for an eye exam using a sliding scale.

Acceptable Practices

Some services may be provided without an eye report if the individual self-reports having a severe vision loss and the eye report is expected. When a person is totally blind, an eye report is not required. For some services, such as low vision assessments, vision rehabilitation therapy, or O&M services, a current eye report is required for persons with residual vision. Agencies may require more stringent visual eligibility requirements (i.e., more severe vision loss) when resources are insufficient to meet needs of consumers.

Unacceptable Practices

It is unacceptable to offer the full array of services allowable by law without documentation of vision loss, even if based on self-report or personal observation. It is unacceptable to have no referral alternatives in place for individuals who do not qualify for services but report difficulty functioning due to vision loss.

Clarifying Comments

Obtaining an eye report from a physician can be difficult, but it is important, particularly for some specialized services, such as low vision, vision rehabilitation therapy, or O&M. Although some consumers may be aware of the nature of their eye conditions, others are not. An eye exam may reveal a correctable vision problem that left untreated could lead to additional vision loss. Archived agency records may be used in some circumstances to document vision loss.

Information and referral services, and other staff services that require staff time and knowledge, may be provided without an eye report or while the eye report is being acquired. Information and referral will be provided to all applicants who request assistance, including those who are not eligible for services based on the eye report.

Prioritizing Consumers

Best Practices

The program specifies an appropriate window for initial contact with consumers, and contacts are made within that timeframe. There is no waiting list for first contact. Information and referral services and collection of intake information may be completed by telephone. The program manager will ensure that the OIB program provides services in a timely way.

When scheduling visits, agencies will have a written policy to prioritize services to consumers based upon one or a combination of factors, including but not limited to:

- Safety concerns
- Potential imminent institutionalization
- Severity of visual impairment
- Availability of personal support
- Transition in living conditions (nursing home/personal care, adult children)
- Time waiting for services

Consumers with vision loss who are older may learn better when instruction is provided in short, frequent lessons. Consequently, multiple instructional sessions will be scheduled in a short time span. While consumers wait for their instructional services to begin, they will receive information and referral services that include periodic contact to address emerging concerns.

Acceptable Practices

Any agency that does not implement best practices will have a plan in place to move toward best practices that includes an expeditious timetable and benchmarks.

Unacceptable Practices

It is unacceptable to have a waiting list for first contact. It is unacceptable to have long waiting times for services. It is unacceptable to have no policy for prioritizing referrals. It is unacceptable to prioritize referrals or to discriminate based upon location (far rural areas seen last), socio-economic status, complexity of case, or cultural barriers.

Clarifying Comments

Although there may not be an official waiting list, consumers sometimes wait long periods for all or some services, such as O&M, or they wait long periods between instructional visits. This is contrary to how services should be provided to older adults. Programs balance quality and quantity of instructional time and services. Prioritizing consumers over prioritizing services is preferred. Have policies/procedures in place to guide professionals in prioritizing their caseloads. Professionals should participate in developing the prioritization protocol.

To serve new consumers in a timely way, older cases must be closed. Cases should not remain open for extended periods unless that time is instructionally necessary. An estimate for case closure should be made at assessment and revised as needed.

Managing Cost of Assistive Devices

Best Practices

Agencies will have guidelines regarding inventory control, supplies, and equipment management. Utilization, maintenance, and consumer or contractor ownership and responsibilities for devices will be clearly delineated. Consumers will be provided information about how to get devices repaired and batteries replaced, as needed.

Agencies will use comparable benefits (e.g., third-party support, such as Lions Club, iCanConnect, etc.) to minimize equipment costs to the agency. Agency resources will be considered in evaluating policies for providing devices.

Other cost saving measures may include bulk purchases, implementing financial needs assessment for co-payments, using innovative ways to pool resources (donated items, VA, Tech Act, VR), developing parameters for device maintenance and replacement, implementing procedures for recycling/refurbishing devices, developing ongoing relationships with collaborating agencies, and securing administrative oversight/approval of expensive items (over $500 or preset amount).

Equipment purchases will be consistent with each consumer's functional needs assessment, and those needs will be documented in the case file. Case documentation will include an explanation of instruction provided and how the device benefits the consumer. Devices will promote consumer health, safety, and independence.

Consumers will be informed about the assistive devices available in the marketplace, regardless of whether or not the program can provide those devices.

Acceptable Practices

Any agency that does not implement best practices will have a plan in place to move toward best practices that includes an expeditious timetable and benchmarks.

Unacceptable Practices

It is unacceptable to (a) provide equipment without consumer assessment, training, and case file documentation; (b) lack inventory control procedures; (c) have inefficient accountability or administrative oversight; or (d) have unclear or inadequate communication with consumers and other stakeholders concerning equipment. It is unacceptable to provide equipment to consumers without ensuring consumers have adequate resources and information to get those devices repaired, including battery replacement.

It is unacceptable to fail to inform consumers about assistive devices available, even when the OIB program cannot provide the device.

Clarifying Comments

Devices that promote consumer health and safety are a priority. Identifying and accessing other funding sources and encouraging consumer responsibility for purchases, regardless of cost, is a positive practice. State-approved vendors for bulk purchases can be an effective practice. Some OIB programs have been successful in getting additional funding from other sources for

programmatic expenses, including assistive technology. When potential opportunities arise to expand funding, staff will pursue efforts to secure it.

Devices for nonessential tasks and some non-specialized devices, such as crock-pots, will be the consumer's responsibility; although, techniques to facilitate use and safety (e.g., raised dots) may be provided. It is inappropriate for states to assume long-term financial responsibilities or provide services such as internet access.

Qualified staff can make purchasing decisions based on consumer assessments for items of specified amounts, as determined by the agency. Purchase of expensive items will require additional oversight.

When agencies allocate funds per consumer for equipment or devices, consumers will be informed about spending caps and assisted in maximizing the impact of the funds allotted to them.

To assist with the conservation of expenses for less expensive items and to facilitate training time, staff may use demonstration kits to show consumers the details or functioning of devices and to give a basic demonstration of how to use the device. Ideally, this would be done when the person expresses interest in the device, rather than after it is received.

Prioritizing Assistive Devices

Best Practices

The OIB program has policies/procedures to define program limits, ownership and maintenance of equipment, and related guidelines to maximize resources and utilization. Consumer needs and safety will be primary factors in distribution of devices and equipment. Consumers will have the opportunity to try out devices or equipment before committing to purchase or receipt (consumer choice based upon assessment). Distribution of devices includes appropriate training in its use for the consumer. When medical equipment is provided, documentation of need will be included in the case file.

Consumers are increasingly requesting accessible applications (apps) for their smartphones. Consumers unaware of these apps will be informed about availability. Staff will be trained by a qualified professional about the availability, cost, features, and operation of apps of potential interest to consumers.

Acceptable Practices

Any agency that does not implement best practices will have a plan in place to move toward best practices that includes an expeditious timetable and benchmarks.

Unacceptable Practices

It is unacceptable to provide the same equipment or no equipment to all consumers without regard to their demonstrated needs, to fail to consider individual consumer needs or delineate ownership, or to fail to provide sufficient training for each piece of equipment.

Clarifying Comments

Although equipment distribution is based on assessed consumer needs, some equipment is essential to most consumers. Training must be provided for all equipment. Frequently distributed equipment includes:

- White cane
- Timepiece/calendar
- Medication delivery/identification device
- Communication device (high contrast markers or pens, bold-lined paper, phones, signature guides, etc.)
- Low-vision device (glare shields, magnifiers, etc.)
- Computer access device (high contrast keyboards, etc.)
- Money identifier

Household items should be externally funded or the responsibility of consumers, unless those items are specifically designed for use by persons with visual impairments and are not readily available at local sources.

Cultural Competency

Best Practices

OIB program managers will facilitate ongoing disability and cultural sensitivity training for staff. Cultural sensitivity training will include, but not be limited to, (a) providing consumer services in a culturally competent way; (b) handling emergency or health situations in ways that are sensitive to diversity issues; (c) considering how the culture influences aging and disability, e.g., definition of independence; (d) responding to the region's specific cultural diversity, including current and emerging trends; (e) using culture/language specific materials; (f) respecting distinct cultural issues of people who are deaf/deafblind; and (g) providing qualified/certified staff for translator/interpreter services.

When appropriate, a cultural liaison/paraprofessional will facilitate access to the community and collaborate with community-based cultural centers. Demographic information about local areas can be obtained from the American Community Survey, conducted by the U.S. Census Bureau, and accessed at blind.msstate.edu/data-corner.

Acceptable Practices

Any agency that does not implement best practices will have a plan in place to move toward best practices that includes an expeditious timetable and benchmarks.

Unacceptable Practices

The following are examples of unacceptable practices: (a) not providing services to a person or population due to lack of understanding/training in cultural issues, (b) forcing cultural values on others, (c) being culturally insensitive, (d) not having an interpreter/translator, or (e) using family members as interpreters.

Clarifying Comments

Staff must be sensitive to other disabilities and to diversity. Agencies will have guidelines regarding culturally sensitive procedures in responding to safety, health, or emergencies. Cultural sensitivity training for staff and volunteers is imperative. Staff must use professional interpreter services (for persons who are deaf, use certified ASL interpreters), not family members, and have materials in multiple languages. Certified ASL interpreters working with people who are deafblind must have training or experience interpreting for that population.

Community groups, clubs, churches, etc. may be able to provide assistance with interpreters or information to promote cultural competence. Training regarding how to work with persons who have hearing loss must be included in diversity training. Competencies and performance in diversity will be assessed regularly by program managers, and plans for promoting cultural competence will be included in staff development plans.

Community Outreach

Best Practices

The state OIB program will have a clearly defined plan and policy concerning statewide outreach activities so that the agency's purpose, eligibility criteria, and information about accessing services can be shared. The outreach plan will include contact with the medical community, specify the types of activities the OIB staff are required to complete, and include provisions for providing education/training about blindness and low vision to community partners who may assist consumers in community integration.

Agencies will have a community outreach packet or toolkit with appropriate information and resources. Community outreach training will be tailored to the occasion and organization and will encourage community support for older people with visual impairments. Outreach will include multiple formats, such as pamphlets, flyers, presentations, press releases, public service announcements, and consistent use of social media/internet resources. Staff will explore and access opportunities to publicize the program and recruit potential consumers. Outreach materials will be culturally sensitive, accessible, and in appropriate languages.

Acceptable Practices

Any agency that does not implement best practices will have a plan in place to move toward best practices that includes an expeditious timetable and benchmarks.

While moving toward best practices, place priority on generating referrals and developing outreach materials.

Unacceptable Practices

It is unacceptable to do no or minimal community outreach or to expect staff to do community outreach without adequate training and resources.

Clarifying Comments

OIB programs will use multiple, innovative strategies to facilitate community outreach. Potential strategies may include staff mentoring staff in conducting community outreach activities, using social media, networking with other organizations, submitting to newsletters of other organizations, exhibiting at health fairs and community festivals, etc.

Many resources are available to develop community outreach materials, including the OIB Technical Assistance Center (www.oib-tac.org). The Center for Disease Control (CDC) has an interactive web application that provides health information by county that may be helpful in developing outreach materials (wwwn.cdc.gov/communityhealth).

The following are suggested topics for community outreach activities:

- Educating about the basics of blindness and low vision. Training about how to work with people with visual impairment, including walking with someone with a visual impairment (human guide).
- Introducing the purpose of the OIB program and how to refer potential users.
- Integrating people with visual impairment into the community and educating about the importance of full inclusion.

- Explaining how older persons with visual impairments can achieve independence.
- Introducing strategies for making an environment accessible and welcoming to persons with visual impairments, including cost effective environmental modifications.
- Avoiding and preventing falls and instructing other caregivers or professionals about this issue.
- Integrating OIB programs with other programs/services that target older adults (e.g., senior centers).

Volunteers and Allied Professionals

Best Practices

Volunteers: Agencies working with volunteers will have a plan for recruitment, background checks, training, supervision, documentation of time and services, recognition, etc. Agencies with no volunteer coordinator may outsource volunteer services, especially for transportation assistance, Support Service Providers (SSP), and reader services. Volunteers are for support in non-professional service delivery. Prior consumers may volunteer in some capacities (e.g., in peer support groups, community outreach, etc.). All volunteers must receive appropriate training, particularly with regard to confidentiality issues, informed consumer choice, consumer safety, and cultural competence.

With consumer consent, and at the discretion of the qualified professional, family members may provide support services as volunteers. Consumer choice regarding the use of a family volunteer must be accommodated. Family members will not function as interpreters except in cases of emergency.

Other Professionals (including Allied Health): Collaborative work with other professionals (e.g., mental health providers, occupational therapists, or physicians) is encouraged but must only occur with consumer consent. University preparation programs, where available, may be a beneficial source for recruiting interns and/or volunteers.

Acceptable Practices

Any agency that does not implement best practices will have a plan in place to move toward best practices that includes an expeditious timetable and benchmarks.

Unacceptable Practices

Volunteers: Involving any volunteer at a level beyond their training and abilities is unacceptable. Volunteers will not replace qualified, well-trained professionals. It is unacceptable to use volunteers who have not had appropriate background checks.

Other Professionals: When OIB staff do not have the expertise or resources to address the consumer's need, referral or collaboration with other service delivery systems or professionals is required. Communicating with or referring consumers to other professionals outside the OIB program without the consent of the consumer is unacceptable.

It is inappropriate to delegate service delivery to another agency with staff who are unqualified for the services rendered.

Clarifying Comments

Agencies with insufficient staff to meet client needs may rely on screened volunteers or other qualified professionals to provide services; however, if the appropriate safeguards are not in place to train volunteers so that consumer privacy, dignity, and quality of services are maintained, then it is best to avoid involving volunteers. Referrals may be made only to providers who have the experience and professional licensure and/or certification to perform the needed service. The consumer should supply appropriate release forms prior to the agency contacting other providers on their behalf.

DEVELOPMENT OF QUALITY STAFF

Staff Qualification

Best Practices

All professional staff serving persons in the OIB programs must be certified (or licensed) in the appropriate discipline (see Appendix) and provide services within their respective professional scope. Professional backgrounds must include training or experience in blindness/low vision and working with older adult populations.

Acceptable Practices

Certified, experienced personnel will closely supervise inexperienced or uncertified professionals with degrees in related fields. A plan with benchmarks and timelines for achieving certification must be in place.

Unacceptable Practices

It is unacceptable for uncertified personnel, regardless of their levels of experience, to provide professional services or certified personnel to provide services outside of their areas of expertise.

Clarifying Comments

Some states have few or, in rare cases, no certified personnel providing services. This practice puts the health and safety of consumers at risk and raises liability concerns for the states and uncertified providers, particularly with regard to orientation and mobility services. It is never appropriate to allow service delivery without quality supervision, particularly if staff are not yet certified or have limited experience working with older adults who have vision loss. Having vision loss does not make a person qualified to provide services. Professionals who have vision loss should also have plans in place to acquire certification or licensure in the appropriate area.

States should select the disciplines appropriate to the services provided and hire personnel with certification (or licensure) and experience in those areas. In cases where staff are already in place without certification or when no certified applicants are available, arrange for supervision by a certified person and develop a plan with benchmarks for progress and a timeline for achieving certification for uncertified personnel. Supervision should include monitoring the competencies of uncertified staff and assuming responsibility for quality service delivery. States are encouraged to pursue contract supervision as appropriate and to explore mentoring and internship programs with benchmarks and timelines for appropriate certification. Agency training is important in professional development and is helpful for certified persons who are potentially inexperienced working with seniors. Agency training is not a substitute for certification or professional education.

Recruitment and Retention

Best Practices

OIB programs will develop recruitment plans targeting licensed/certified professionals that include competitive salaries and benefits packages, resources for staff development, and professional supervision. Programs may use technology, such as online job sites and social media, for recruitment and actively recruit with universities and professional organizations.

Programs will develop retention plans that promote employee growth in their respective specialties and in the organization. Create a work environment that is innovative, flexible, positive, and safe; provide needed job accommodations; and recognize staff achievements.

Acceptable Practices

When financial resources are limited or determined by other systems, it is acceptable to use available resources to promote staff development leading to certification (or licensure) and create a work environment that is respectful of the staff and allows them as much autonomy as possible. The agency should keep ongoing documentation of local staffing needs and competitive salary rates.

Any agency that does not implement best practices will have a plan in place to move toward best practices that includes an expeditious timetable and benchmarks.

Unacceptable Practices

It is unacceptable to provide work environments that do not support professional growth (i.e., certification/licensure); provide accommodations; promote respect of staff, including supervisors or administrators being dismissive of staff concerns; or where staff feel unsafe performing their job duties. Recruitment strategies limited to posting job announcements on state websites or job services are unacceptable. An absence of recruitment and retention policies is unacceptable.

Clarifying Comments

There are shortages of certified personnel in many parts of the country. Some state OIB programs have limited control over salary structures in their agencies. These issues require administrators to be more aggressive in recruiting, including identifying potential candidates, participating in internship programs through universities, and developing retention strategies that make employment attractive to new and existing staff. With adequate education and support, employees within the agency may be recruited for targeted professional positions. A positive work environment becomes even more important when salaries and benefits are limited, so recognition of staff autonomy and accomplishments, support for professional development, flexible schedules, and responsive supervisors become critical factors in recruitment and retention.

Agencies should use available resources to pursue continuing education for staff, including promoting acquisition and retention of certification (or licensure), encouraging hiring and retention of staff with disabilities and providing appropriate accommodations, and maintaining current technology and providing staff instruction in its use.

Staff Education and Continuing Education

Best Practices

Each professional staff person will have an individualized plan, consistent with his or her job duties, for continuing education and maintaining certification or licensure that includes a periodic behavioral demonstration of competencies. Professional qualifications will include education and experience working with persons with visual impairments and working with older populations. Agency resources will be committed to supporting employees in achieving the goals in their individualized plans.

Acceptable Practices

Uncertified staff enrolled in educational programs, internships, or mentoring programs leading to certification/licensure may provide services under the direct supervision of an appropriately certified or licensed professional. Uncertified staff will have established benchmarks and timelines for achieving certification/licensure or necessary experience. Staff with experience or training working with younger age groups will be supervised or mentored until they demonstrate behavioral competency working with older populations.

Any agency that does not implement best practices will have a plan in place to move toward best practices that includes an expeditious timetable and benchmarks.

Unacceptable Practices

Service delivery by the following are unacceptable without supervision of a certified professional: (a) uncertified/unlicensed persons, regardless of whether they have personal or professional experience in the field, or (b) certified/licensed persons who lack experience working with older populations or with persons with visual impairments. It is unacceptable for the agency to fail to support staff efforts to attain or maintain appropriate certification or licensure.

Clarifying Comments

Because service providers must assess consumer needs or skills, in addition to planning, implementing, and evaluating services, these services must be provided by skilled, experienced professionals with the appropriate certification or licensure. Staff who are not certified or licensed must be supervised by an appropriately certified or licensed professional. When certified or licensed staff lack experience working with older populations or persons with vision loss, those staff must receive experiential training, with supervision, until they demonstrate competencies in appropriate service areas.

Performance based assessments will be used to evaluate staff competency in tasks associated with their professional practice areas. Administrators will assist staff in acquiring continuing education, documenting it, and sharing knowledge and information with other staff.

Paraprofessionals

Best Practices

OIB programs will have a specific description of the role and scope of paraprofessionals in the agency that will not allow paraprofessionals to function outside of those parameters. Paraprofessionals will always work under the supervision of appropriate, certified/licensed professionals to assist or support service delivery.

Each agency will develop a list of competencies for paraprofessionals and clearly define what activities can and cannot be performed in the paraprofessional role. In some agencies, there are individuals who work as cultural liaisons or accessibility aides with unique paraprofessional roles, such as driving or reading. These paraprofessionals will also receive appropriate training and supervision.

Acceptable Practices

Any agency that does not implement best practices will have a plan in place to move toward best practices that includes an expeditious timetable and benchmarks. Use of paraprofessionals will be avoided until best practice guidelines are achieved.

Unacceptable Practices

It is unacceptable for paraprofessionals to provide professional services. Services to support instruction or skills without direct supervision from a certified/licensed professional are also unacceptable.

Clarifying Comments

Paraprofessionals can be helpful in supporting service delivery, provided they are under the direct supervision of a certified or licensed professional in the area of service. Paraprofessionals are typically not certified or licensed to provide services and do not operate under a professional Code of Ethics; therefore, they should not provide professional services, including assessment and instruction.

The OIB program manager has the responsibility to monitor the use of paraprofessionals to ensure that paraprofessionals are not functioning outside of their scope of duties and are functioning with supervision from a certified/licensed professional. Professionals will monitor paraprofessional work to prevent them from functioning beyond their level of expertise or outside their defined scope of work.

CONCLUSION

In Closing

The best practices described in this document are aspirational, not enforceable. The intent is to guide providers as they strive to achieve the highest possible quality in their service delivery systems. This list of best practices is not exhaustive. It is our hope and expectation that this document will serve as a platform from which to develop additional best practice guidelines as well as to provide an impetus to conduct evidence-based research regarding effective practices in administration and service delivery in OIB programs.

This document is also fluid. We will review feedback from service providers, administrators, and other professionals in the field of blindness and low vision with content experts and release revised versions of the document, as appropriate. Toward that end, your comments regarding this document are encouraged. Please visit the OIB-TAC Community of Practice, which houses a copy of this document for download, and give your feedback (www.oib-tac.org).

APPENDIX

Acronyms and Terminology

7-OB	Form of aggregate data that is to be completed by agencies annually regarding independent living services for older blind persons (also known as 7-2 or Title VII, Chapter 2)
ACVREP	Academy for Certification of Vision Rehabilitation and Education Professionals (www.acvrep.org) – Provides certification program information and resources for Certified Vision Rehabilitation Therapist (CVRT), Certified Orientation and Mobility Specialist (COMS), Certified Low Vision Therapist (CLVT), and Certified Assistive Technology Instructional Specialist for People with Visual Impairments (CATIS)
AER	Association for Education and Rehabilitation of the Blind and Visually Impaired (www.aerbvi.org) – Professional association for service providers of individuals who are blind or visually impaired
AFB	American Foundation for the Blind (www.afb.org) – National nonprofit organization committed to creating a more equitable world for individuals who are blind or visually impaired
AOTA	American Occupational Therapy Association (www.aota.org) – Professional organization that provides state policy and licensure information for occupational therapists
ARMD or AMD	Age-Related Macular Degeneration
ASL	American Sign Language
AT	Assistive Technology
AVRT	Association of Vision Rehabilitation Therapists (formerly MACRT) (www.avrt.org) – Professional organization for vision rehabilitation therapists from public and private sectors across the U.S.
B/VI or BVI	Blindness and/or visual impairment
CATIS	Certified Assistive Technology Instructional Specialist for People with Visual Impairments (from ACVREP)
CDC	Centers for Disease Control and Prevention – One of the major operating components of the Department of Health and Human Services that works to protect America from health, safety, and security threats
CDMS	Certified Disability Management Specialist (www.cdms.org)
CFR	Code of Federal Regulations of the United States of America
CLVT	Certified Low Vision Therapist (from ACVREP)
COMS	Certified Orientation and Mobility Specialists (from ACVREP)
Consumer	Individual who is blind or vision impaired and receiving, or had previously received, services from an agency for persons who are blind

CRC	Certified Rehabilitation Counselor
CVRT	Certified Vision Rehabilitation Therapist (also known as Rehabilitation Teacher) (from ACVREP)
DB	Deafblind – Individuals with severe visual impairment who also have severe hearing loss
DSA	Designated State Agency (vocational rehabilitation agency)
FVA	Functional Vision Assessment – Done by a vision professional in a natural setting, such as at home, work, etc.
HKNC	Helen Keller National Center for Deaf-Blind Youths and Adults (www.helenkeller.org/hknc) – Headquartered in Sands Point, NY, with 10 regional offices throughout the U.S., provides training and resources exclusively to individuals age 16 and over who have combined vision and hearing loss
IL(S)	Independent Living (Services) – Rehabilitation services for persons without vocational objectives
Informed Consent	Current movement to empower consumers through information and knowledge
LB	Legally Blind – Refers to a central visual acuity of 20/200 or less in the better eye, with the best possible correction, and/or a visual field of 20 degrees or less
LPO	Light Perception Only – Not able to see details but can perceive the difference between light and dark
LVA	Low Vision Aid – Aid or device, such as a talking watch or magnifier, to assist an individual with daily activities
LVE	Low Vision Exam done by an eye care professional in a clinical setting such as a doctor's office or at a rehabilitation facility
LVT	Low Vision Therapist or, when certified by ACVREP, CLVT
NBPCB	National Blindness Professional Certification Board (www.nbpcb.org) – Provides certification program information and resources for National Orientation and Mobility Certification (NOMC), National Certification in Rehabilitation Teaching for the Blind (NCRTB), National Certification in Literary Braille Certification (NCLB), and National Certification in Unified English Braille (NCUEB)
NCLB	National Certification in Literary Braille (from NBPCB)
NCRTB	National Certification in Rehabilitation Teaching for the Blind (from NBPCB)
NFB	National Federation of the Blind (www.nfb.org) (consumer group)

NIDILRR	National Institute on Disability and Independent Living Rehabilitation Research (NIDILRR) – Federal government's primary disability research agency (formerly NIDRR)
NLP	No Light Perception
NOMC	National Orientation & Mobility Certification (from NBPCB)
NRTC	National Research and Training Center on Blindness and Low Vision (blind.msstate.edu)
O&M	Orientation and Mobility
OIB	Title VII, Chapter 2 – Older Blind Program, also known as Independent Living for Older Individuals who are Blind (ILOIB) – Administered by state VR agencies and funded by RSA as part of the VR program
OIB-TAC	Older Individuals who are Blind Technical Assistance Center (www.oib-tac.org)
OT	Occupational Therapist
PWD	Person With a Disability
RCB or RCD	Rehabilitation Counselor for the Blind or Rehabilitation Counselor for the Deaf
RESNA	Rehabilitation Engineering Society of North America (www.resna.org) – Certifies assistive technology specialists
RSA	Rehabilitation Services Administration (RSA) – Federal agency charged with oversight of programs for adults with disabilities including older blind adults
RT	Rehabilitation Teacher – Also known as VRT or, if certified through ACVREP, CVRT
SSP	Support Service Providers
Title VII, Chapter 2	(AKA 7-2 or 7-OB) Legislative section that provides for IL services for older blind (OB) persons.
VA	Veterans Affairs; U.S. Department of Veterans Affairs
VR	Vocational Rehabilitation – Federal/state program designed to help persons with disabilities find employment
VRT	Vision Rehabilitation Therapist also known as Rehabilitation Teacher (RT) or, if certified through ACVREP, CVRT

Expert Panel

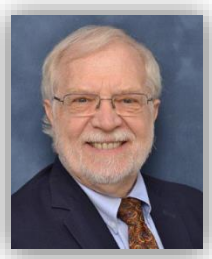
Doug Anzlovar, MS, CVRT

Doug is the Chief Learning Officer at the Hadley Institute for the Blind and Visually Impaired, where he serves as a member of the senior leadership team, oversees a 26-member faculty, and is involved in curriculum decisions and policy development. Prior to joining Hadley, Doug worked as a teacher of the visually impaired in the Chicago Public Schools for nearly ten years. Doug also served as an assistive technology specialist for ten years and provided computer evaluations and training to all age groups. Doug holds a MS in adult rehabilitation of the blind and a BS in special education with an emphasis in teaching the visually impaired, both from Northern Illinois University. Doug is a Certified Vision Rehabilitation Therapist. He served on the Board of Directors for the Association of Vision Rehabilitation Therapists (AVRT) and is President of the Illinois Chapter of the Association for the Education and Rehabilitation of the Blind and Visually Impaired (IAER). Hadley Institute also provides consulting services to the OIB-TAC.

Beverly Berg, CRC, CVRT

Beverly received a MS in Blindness Rehabilitation from Western Michigan University in 1985. Since then, she has worked as a vision rehabilitation therapist, rehabilitation counselor supervisor, and program administrator. Beverly is a Certified Rehabilitation Counselor and Certified Vision Rehabilitation Therapist. She maintains membership in the Montana Association for Rehabilitation and the Association for Education and Rehabilitation of Blind and Visually Impaired. She is also a board member of Low Vision Montana. She has worked for Blind and Low Vision Services for 38 years, and is the OIB Program Manager in Montana as well as supervising services for the blind in Montana. She is serving as a representative of NCSAB on this panel.

John E. Crews, DPA



John is a retired Health Scientist for the Vision Health Initiative in the Division of Diabetes Translation at the U.S. Centers for Disease Control and Prevention. John has forty years of experience in vision rehabilitation, disability, and vision research. He managed a rehabilitation program for older adults for the Michigan Commission for the Blind between 1977 and 1992. In 1992, he joined the Department of Veterans Affairs' Rehabilitation Research and Development Center on Aging in Atlanta. Later, John was the Executive Director of the Georgia Council on Developmental Disabilities. He also served as Research Director at the NRTC for several years before he joined CDC in 1998. John's research interests include vision impairment and aging, multiple chronic conditions and vision, caregiving, and disability.

Elizabeth Biber-DeShields, MAS

Elizabeth (Liz) has been the Independent Living and Clinical Services Coordinator for the New Jersey Commission for the Blind and Visually Impaired (CBVI) for three of her nine years at CBVI; this includes serving as OIB Program Manager in NJ. Liz develops policies, procedures, and programs for independent living services for consumers of all ages in the areas of Orientation and Mobility, Rehabilitation Teaching and Eye Health Nursing. She directly supervises Project Better Eye Health Services Treatment (BEST), the prevention unit, and Assistive Support Programs for Independence Renewal and Education (ASPIRE). Prior to being employed at CBVI, Liz worked for both private and state agencies that served persons with developmental disabilities. She held various positions along the way: Behavior Therapist, Manager of the Habilitation Services Department, Quality Assurance Specialist, and is a certified investigator of abuse and neglect allegations of the developmentally disabled. She earned her BA in Psychology and Therapeutic Recreation from Glassboro State College, and her MAS in Administrative Science from Fairleigh Dickinson University.

Don Golembiewski, MA, CVRT

After receiving a MS in Rehabilitation Teaching from Western Michigan University in 1977, Don worked for nine years as an itinerant rehabilitation teacher for blind adults in Wisconsin and later served as the coordinator of the federal grant to provide Independent Living services for Older Blind Individuals for Wisconsin for 13 years. Don was the Director of Outreach and Distance Education instructor for The Hadley School for the Blind from 2001 until 2012. Don served as a chair of both the Rehabilitation Teaching Division (now VRT) and the Aging Services Division of AERBVI. Those leadership experiences continue to help guide his work with consumers, their family members and other blindness professionals. He remains active as a Lion and has been a Lions Zone Chairman and served as president of two different clubs. One of his goals has been to enable blindness professionals to find ways to collaborate and enlist Lion support for local blindness causes. He also serves as a consultant for OIB program evaluations to the NRTC at Mississippi State University.

Nora Griffin-Shirley, PhD, COMS

Nora, a professor in the Special Education Program at Texas Tech University, is the Director of The Virginia Murray Sowell Center for Research and Education in Visual Impairment, Coordinator of the Orientation and Mobility Program, and Coordinator of the Sensory Impairment and Autism Program. Nora has served as the principal investigator on grants and has published articles and 3 books. She has also received numerous awards and recognitions and served as a member of numerous Texas Tech committees. Additionally, Nora has given over 130 presentations and held leadership roles in the Association for Education and Rehabilitation for Blind and Visually Impaired and in the Division of Visual Impairment of the Council for Exceptional Children.

Deborah Harlin, TVI

Deborah is currently the Director of Information, Research, and Professional Development at the Helen Keller National Center for Deaf-Blind Youths and Adults in New York. She is an NYS certified Teacher of the Blind and Visually Impaired. Deb has 24 years of experience working with deaf-blind people at the Helen Keller National Center, from direct services to program management and in her current position. She has been responsible for HKNC's Adaptive Technology Center as well as the NYS Deaf-Blind Equipment Distribution Program (iCanConnect). Deb currently oversees HKNC's Senior Adult Specialist, who runs the Confident Living Programs for Seniors 55 and older with combined vision and hearing loss.

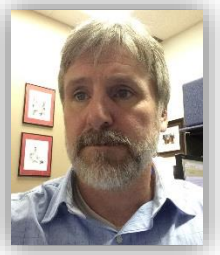
Matthew Haynes, MS, CRC

Matthew is currently the OIB Program Manager/Coordinator of Alabama's older blind program OASIS – Older Alabamians System for Information and Services – at the Alabama Department of Rehabilitation Services. He earned his MS in Rehabilitation Services from Auburn University in 2003 and is a Certified Rehabilitation Counselor. Prior to becoming the Program Coordinator, Matthew was a Vision Rehabilitation Therapist for the OASIS Program for three years, and Vocational Rehabilitation Counselor for the Blind and Visually Impaired for five years. He is representing AFB's Agenda on Vision and Aging in the 21st Century (AVA21) Goal 2 which is related to personnel needs in the older blind program.

Tandra Hunter-Payne, MEd, CPhT

Tandra is a Program Manager with the Division of Rehabilitation Services (DORS), Office for Blindness and Vision Services (OBVS), in Maryland. She has worked for DORS for over 19 years as a rehabilitation counselor, supervisor, and now as the program manager for the OBVS. In that role, she is responsible for overseeing the Independent Living Older Blind grant, blind services at the Workforce and Technology Center, staff training, and statewide deaf-blind services.

Edward Lecher



Ed is currently the OIB Program Manager/Director of the Minnesota State Services for the Blind Senior Services and has been with this agency for 14 years. Ed has a BS in Public Administration. He started his career with the State of Oregon as director of a low-income health facility. He has been the director of several Boy & Girls Club organizations and has held a number of leadership positions in Kentucky, Oregon, Wisconsin, and Minnesota. He came to Minnesota State Services for the Blind in an administrative role but moved into the OIB leadership position in 2013.

John Mascia, AuD

John is the 17th President of the Alabama Institute for Deaf and Blind, and has been in this position since 2013. John received his doctorate in Audiology from Pennsylvania College of Optometry. He holds both a MS in Audiology and a BA in Speech Pathology/audiology from Hofstra University. John is a member and past president of Lions Club International, is active on several boards and advisory committees, and is a member of Leadership Alabama. He worked for a number of years at the Helen Keller National Center for Deaf-Blind Youths and Adults, most recently serving as National Director of Field Services, and led a subcontract with the NRTC on the NIDRR-funded exploratory research project "Persons Aging with Hearing and Vision Loss."

Roxann Mayros, MS

Roxann is the Chief Executive Officer of VisionServe Alliance, a national consortium of 100+ nonprofit organizations serving people with severe vision loss. In her current position, she has created a knowledge network and support system for leaders in vision rehabilitation, integrated best practices nationwide, created a leadership training program for up-and-coming leaders in vision rehabilitation, and galvanized individuals and groups around issues of national relevance such as the Low Vision Rehabilitation Demonstration Project and the Workforce Innovation and Opportunity Act. VisionServe Alliance also provides consulting services to the OIB-TAC. Roxann has served as Executive Director/CEO of three major vision rehabilitation agencies, serving infants to seniors, and has served in leadership roles on several national boards and advisory councils that focus on vision loss. She has provided expert consultation in nonprofit management, strategic planning, board development, and organizational turn-arounds. Roxann holds a BS in business, a MS in nonprofit management, and certificates in nonprofit leadership.

John McMahon, PhD, CVRT, CLVT

John earned his MA Arts in Rehabilitation Teaching from Western Michigan University in 1985. Since that time, he has worked as a Vision Rehabilitation Therapist (VRT) and program administrator in Maine and as a VRT, Vocational Rehabilitation Counselor, and Low Vision Therapist in Michigan. John has served in a variety of local and international AER positions, ranging from Board of Directors and President of the Michigan chapter, Board of Directors of the Northeast Chapter, and as Chair-elect, Chair, and Immediate Past Chair of the Vision Rehabilitation Therapy Division of the Association for the Education and Rehabilitation of the Blind and Visually Impaired (AER). John serves on the Board of Directors of AER. In addition, John currently holds certification in Vision Rehabilitation Therapy and Low Vision Therapy. He earned his PhD in Interdisciplinary Health Sciences from Western Michigan University in 2013. John currently operates Northern Lights Vision Quest, LLC, a business consulting on issues involving education, rehabilitation, employment, and independent living for persons who are blind or visually impaired. He also serves as a consultant to the OIB-TAC.

Cheri Nipp, MS, OTR/L, SCLV

Cheri holds the American Occupational Therapy Association's Specialty Certification in Low Vision. Her BS in occupational therapy was completed at the University of Alabama at Birmingham (UAB) in 1990. In 2010, Cheri obtained her graduate certificate in low vision rehabilitation and a post professional Master's degree in occupational therapy with an emphasis in low vision rehabilitation from UAB. Cheri's experience is not limited to working with clients with a single condition (e.g., visual-vestibular dysfunction or focusing deficiencies); she sees many clients with multiple chronic health conditions, such as hearing impairments, arthritis, or diabetes, in combination with visual impairment. Her caseload includes adults who have deficiencies in acuity and visual field as a result of eye disease and other conditions related to brain injury. Cheri coordinates the Low Vision Rehabilitation Program at North Mississippi Medical Center Retina Clinic. She is active in providing community education on low vision at various events and does guest lectures to the local Residency program and community college.

Priscilla Rogers, PhD

Pris is Acting Director for the American Foundation for the Blind Web Programs and is Program Manager for VisionAware.org, a website for people new to vision loss. While working for AFB, she worked with the aging team to implement the National Agenda on Aging and Vision Loss; initiated the eLearning program; directed Senior Site, a website for older people with vision loss; and helped initiate Esther's Place, a special demonstration apartment at AFB's Center on Vision Loss in Dallas. Her background includes a BA from Eckerd College, a MA in gerontology from the University of South Florida, and a PhD in special education with an emphasis in vision and aging from Florida State University. She started her career in 1975 at the Tampa Lighthouse for the Blind, where she directed one of the initial programs in the country serving older persons with visual impairments. In 1978, she became the first executive director of Channel Markers for the Blind (now Lighthouse of Pinellas) and Bureau Chief of Client Services for the Florida Division of Blind Services. She also served as Commissioner of the Department for the Blind in Kentucky. Pris has authored several articles on vision and aging, co-authored several books, and spoken at conferences across the country.

Bernard A. Steinman, PhD

Bernard is an assistant professor in the Department of Human Development and Family Science at the University of Wyoming. He is a gerontologist by training, and his areas of interest focus on late life vision impairments and their effects on functioning and health. Bernard has published articles on fall prevention/environmental modification, aging with vision and hearing loss, long-term care options for older and middle-aged people with chronic conditions and disabilities, and successful aging in place within the community. He is interested in methods and evaluation designs used in assessing needs, implementation, and outcomes of programs for older adults. Bernard is currently heading up Age-Friendly Laramie, a community development initiative designed to promote healthful and productive aging-in-place for people of all ages and abilities.

Sylvia Stinson-Perez, CVRT

Sylvia has over 20 years of experience in the field of vision rehabilitation and 5 years in higher education. She has Master's degrees in Social Work, Visual Disabilities Education, and Business Administration. Sylvia is also a Certified Vision Rehabilitation Therapist. Sylvia has been the CEO/Executive Director of the Lighthouse for the Visually Impaired and Blind for 10 years. The Lighthouse provides a full range of vision education, rehabilitation, and employment services to people who are blind and visually impaired. She has been an active member of AER, including previously serving as the President of the Florida Chapter. Sylvia also has done consulting, including most recently with the MSU NRTC Older Blind Project. She is visually impaired herself and believes strongly in advocacy, best practice, and professional development.

Joe Strechay

Joe is currently the Director of the Bureau on Blindness and Visual Services for the Commonwealth of Pennsylvania, where he also supervises the OIB program. Previously, he worked with the American Foundation for the Blind as their Transition Specialist, managing the nationwide employment-mentoring program CareerConnect®, and with the New Jersey Commission for the Blind and the Florida Department for the Blind overseeing transition and employment initiatives. Joe graduated from Florida State University. He is a member of the National Federation of the Blind, serving as the NFB representative for the OIB-TAC, and is involved in several professional organizations.

About OIB-TAC

Vision loss is one of the many challenges of aging. The ability to remain independent, productive, and involved need not change because of vision loss. Each state receives federal funding with the goal of developing an effective program to meet the needs for independence of older individuals with blindness and visual impairments (OIB). The OIB program is designed to help seniors age in place with dignity and independence. The Older Individuals who are Blind Technical Assistance Center (OIB-TAC) is a federally-funded center designed to assist state OIB programs in becoming as effective as possible in meeting this goal.

A development of the National Research and Training Center on Blindness and Low Vision (NRTC) at Mississippi State University, OIB-TAC is a collaborative project involving the American Foundation for the Blind (AFB), the Helen Keller National Center for Deaf-Blind Youths and Adults (HKNC), and Hadley Institute for the Blind and Visually Impaired. All activities are designed to improve the operation and performance of OIB programs through improved community outreach, use of best practices in the provision of services, improved data reporting and analysis, and stronger financial and management practices. The OIB-TAC website (www.oib-tac.org) facilitates training, technical assistance, interagency collaboration, and electronic discussion among OIB service providers, including subcontracting CRPs, and related agencies. All Community of Practice activities will promote communication, quality service delivery, program administration, linking resources, and professional support.

Our Topic Areas

- Community outreach
- Best practices in provision and delivery of services
- Program performance, including data reporting and analysis
- Financial and management practices, including administrative compliance

Our Services

- Intensive Training and Technical Assistance
- Electronic Training
- OIB Collaborative
- Community of Practice

Contact Information

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Project Partner Websites

www.afb.org
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OIB-TAC Staff

BJ LeJeune, MEd, CVRT, CRC
OIB-TAC Project Director and NRTC Training Supervisor
BJ supervises and provides national training activities for the NRTC. She draws from her direct service experience as well as her research experience with Program Evaluation of individual state OIB Programs and her leadership experience as Project Director for a NIDILRR funded project, Persons Aging with Hearing and Vision Loss, to provide leadership for the OIB-TAC. BJ is a Certified Vision Rehabilitation Therapist, Certified Rehabilitation Counselor, and worked for a number of years as a Certified Interpreter of the Deaf.

Adele Crudden, PhD, CRC, CDMS
Professor
Adele is a professor in the social work program and a researcher at the NRTC. She is supporting the OIB project in program evaluation activities and conducts research for the NRTC's NIDILRR funded projects. Adele supervised an OIB program while directing a residential rehabilitation center for the blind. She is a Certified Rehabilitation Counselor, a Certified Disability Management Disability Specialist, a Mississippi licensed master social worker, a Mississippi and Louisiana licensed professional counselor, and a Louisiana licensed Vocational Rehabilitation Counselor. She has worked in private and state rehabilitation agencies.

Kendra Farrow, MA, CVRT
Research and Training Associate
Kendra is a Certified Vision Rehabilitation Therapist with 14 years of direct service experience. In 2014, she joined the NRTC, where she designs and conducts training activities, leads the development and oversight of targeted training opportunities through the OIB-TAC grant, identifies and reviews content for the OIB-TAC Community of Practice, provides technical assistance, and leads several older blind program evaluation projects.

Bill Tomlin, MEd
OIB-TAC Project Manager
Bill serves as project manager for the older blind program. Prior to joining the OIB-TAC team, Bill served in the United States Army for 25 years. In his last military assignments, Bill served in a variety of capacities, including working with local, state, and federal agencies to facilitate the coordination of disaster preparedness.

Doug Bedsaul, MA

Research and Training Coordinator

Doug works on a variety of projects at the NRTC, including disseminating research, external evaluations of older blind programs, and overseeing online continuing education. He led the initial development of the OIB-TAC website and coordinates the continued activities of the OIB Community of Practice.

Sophie Kershaw-Patilla, MA

Communications Specialist

Sophie assists the NRTC with optimizing the promotion of activities and research results across a variety of audiences. Sophie holds a master's degree in educational psychology and has previous experience working in the public and private business sector providing professional communications management, strategic planning development and implementation, and accounting and human resource coordination.

OIB TAC

Older Individuals who are Blind – Technical Assistance Center

The contents of this document were developed under a grant from Rehabilitation Services Administration (RSA) under U.S. Department of Education grant No. H177Z150003. However, these contents do not necessarily represent the policy of RSA and should not indicate endorsement by the Federal Government.

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