

DSB-STEP

Division of Services for the Blind
Senior Technology Education Program



*Independent Living Services
For Older Individuals Who Are Blind*

State of Arkansas
Title VII-Chapter 2
Program Evaluation Report
Federal Fiscal Year 2013

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State of Arkansas
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FFY 2013

Title VII - Chapter 2 Older Blind Program

INTRODUCTION

Background

The Arkansas Division of Services for the Blind (DSB) receives funding under Title VII, Chapter 2 of the Rehabilitation Act of 1973, as amended, to provide independent living (IL) services to blind and visually impaired individuals age 55 and older in the state of Arkansas. Title VII, Chapter 2 program funding is provided to state-federal vocational rehabilitation (VR) agencies to support IL services for persons age 55 or older whose severe visual impairment makes competitive employment difficult to obtain but for whom IL goals are feasible. DSB entered into a contractual agreement with World Services for the Blind to provide IL services under the federal program beginning May 2011. Services were previously provided in-house. DSB is one of only eight states receiving federal funding since the inception of Title VII-Chapter 2 funding. A brief history of the federal Older Individuals who are Blind (OIB) program follows.

Federal funding for blindness-specific IL services under the civilian VR program was first authorized under the Rehabilitation Act of 1973. This allowed state VR agencies to conduct 3-year demonstration projects for purposes of providing IL services to older blind persons (American Foundation for the Blind, 1999). In response to the success of these early projects, the 1978 Rehabilitation Act Amendments to Title VII - Part C (now Title VII - Chapter 2) authorized

discretionary grants to state VR programs to provide IL services for individuals age 55 or older who are blind or visually impaired. Funding for these services did not begin until congressional appropriations were allocated in 1986.

Subsequently, state VR agencies were invited to compete for available dollars, and in 1989, 28 IL programs were funded (Stephens, 1998).

In federal fiscal year (FFY) 2000, the Chapter 2 Older Blind program reached a major milestone when it was funded at \$15 million (a 34% increase) and was thus moved from a discretionary grant program to a formula grant program. (The Rehabilitation Act of 1973, as amended, provides for formula grants in any fiscal year for which the amount appropriated under section 753 is equal to or greater than \$13 million.) These formula grants assure that all states, the District of Columbia, and the Commonwealth of Puerto Rico receive a minimum award of \$225,000. Guam, American Samoa, the United States Virgin Islands, and the Commonwealth of the Northern Mariana Islands are assured a minimum allotment of \$40,000. Specific allotments are based on the greater of (a) the minimum allotment or (b) a percentage of the total amount appropriated under section 753. This percentage is computed by dividing the number of individuals 55 and older residing in the state by the number of individuals 55 and older living in the United States (Rehabilitation Act Amendments of 1998).

The overall purpose of the Title VII, Chapter 2 program is to provide IL services to individuals who are age 55 and older whose significant visual impairment makes competitive employment extremely difficult to attain but for whom independent living goals are feasible. IL programs are established in all 50 states, the District of Columbia, and the territories. These programs help older blind persons adjust to blindness and to live more independently in their homes and communities.

Under federal regulations (Rehabilitation Act of 1973, as amended, Rule, 7-1-99), IL services for older individuals who are blind include:

1. services to help correct blindness, such as--

- A. outreach services;
- B. visual screening;

- C. surgical or therapeutic treatment to prevent, correct, or modify disabling eye conditions; and
 - D. hospitalization related to such services;
2. the provision of eyeglasses and other visual aids;
 3. the provision of services and equipment to assist an older individual who is blind to become more mobile and more self-sufficient;
 4. mobility training, braille instruction, and other services and equipment to help an older individual who is blind adjust to blindness;
 5. guide services, reader services, and transportation;
 6. any other appropriate service designed to assist an older individual who is blind in coping with daily living activities, including supportive services and rehabilitation teaching services;
 7. independent living skills training, information and referral services, peer counseling, and individual advocacy; and
 8. other independent living services.

Services generally provided by the state IL programs include blindness- and low vision services, such as training in orientation and mobility, communications, and daily living skills; purchase of assistive aids and devices; provision of low vision services; peer and family counseling; and community integration services.

Population and Prevalence Rates Estimates

Population estimates from the U. S. Bureau of the Census 2010 American Community Survey (ACS; 2010) data (Summary File 1) show that there were approximately 770,972 Arkansans age 55 and above in 2010. This is an increase of about 35,000 individuals from estimates using 2008 Census data. Although we were unable to disaggregate 2010 estimates by race and ethnicity, less recent 2008 ACS disaggregated estimates are presented in Table 1.

Table 1: Arkansas Population by Race/Ethnicity, Age 55 & Above, 2008 American Community Survey (ACS)

Race/Ethnicity	2008	% of Population
White (non-Hispanic)	642,340	87.3%
Black (non-Hispanic)	74,315	10.1%
Native American (non-Hispanic)	2,945	0.4%
Asian American (non-Hispanic)	3,680	0.5%
Other (non-Hispanic)	4,415	0.6%
Hispanic	8,090	1.1%
Total Population	735,785	100%

Prevalence rates. We were unable to determine prevalence of VI among individuals age 55 and above in Arkansas but did find rates for individuals 65 and above. Estimated numbers and rates of VI are reported in Table 2 (Erickson & von Schrader, 2013). Prevalence of visual impairment is higher for individuals age 65 and older residing in Arkansas compared with the nationwide rate (8.7% vs. 6.8%). Rates are also higher for White, non-Hispanic (8.0% vs. 6.2%) and African American, non-Hispanic (13.0 vs. 9.8%). Prevalence rates and numbers for Native Americans/Alaska Natives, Asian Americans, and the "other" category in Arkansas are not included because small sample sizes resulted in a large margin of error relative to the estimate.

Table 2: Arkansas and U.S. Prevalence Rates of Visual Impairment by Race/Ethnicity, Age 65 & Above, 2011 ACS

Race/Ethnicity	Arkansas		U.S.
	%	Number	%
White, non-Hispanic	8.0%	29,200	6.2%
Black, non-Hispanic	13.0%	4,800	9.8%
Native American, Alaska Native non-Hispanic*			13.1%
Asian American, non-Hispanic*			5.7%
Other, non-Hispanic*			9.2%
Hispanic, all races*			10.0%
Total, all races/ethnicity	8.7%	35,900	6.8%

* Sample sizes too small to estimate numbers, percentages

The Arkansas OIB Service Delivery Model

The Arkansas Division of Services for the Blind operates under the Arkansas Department of Human Services with the guidance of a policy-making board. Using federal Title VII-Chapter 2 federal funds and state matching funds, DSB has responsibility for serving persons with significant visual impairments who are 55 years and older under the Rehabilitation Services Administration (RSA) OIB program. FFY 2013 is the third year that DSB has entered into a performance-based purchase of services contract with World Services for the Blind (WSB) to provide IL services to individuals who meet eligibility requirements for RSA's OIB Program. Under WSB's Senior Technology Education Program (DSB-STEP), services to be provided to consumers statewide include outreach, assessment, orientation and mobility, and instruction in activities of daily living, including assistive technology. The majority of direct services are provided on an itinerant basis by a doctoral-level external consultant with formal training as a teacher of students with visual impairments. As needed, World Services staff, including university-trained rehabilitation teachers and orientation and mobility (O&M) instructors, provide center-based or itinerant services to eligible consumers. A more detailed review of the DSB-STEP service delivery process is included in findings from the annual on-site review (p. 49).

Contract deliverables. Total liability for the FFY 2013 contract with WSB was limited to \$352,600. The contract beginning date was July 1, 2012, and the ending date was June 30, 2013. Program deliverables and rates of pay were as follows:

- A. Conduct program outreach to a minimum of 230 individuals presumed eligible for the federal Older Individuals who are Blind (OIB) Program, either on-campus or in local communities across the state. Secure commitment from a minimum of 86 such individuals for participation in the DSB-STEP (Senior Technology Education Program) Program by May 18, 2013. Submit letter to DSB Chief of Field Services by May 18, 2013, along with report certifying number of outreach contacts, geographic location, and date, and listing names of trainees committed to participate in the DSB-STEP Program.
 - o Rate per Referral--\$100.00

- B. Conduct Intake Assessment of a minimum of 86 DSB-STEP Program Trainees using the DSB model to determine individual independent living skills and program eligibility under the federal OIB program, either on-campus or in local communities across the state. The DSB Model includes the Mississippi State University (MSU) on-line assessment on each OIB consumer for whom an application is taken and World Services for the Blind (WSB) will determine eligibility on each program participant. Submit letter bill to DSB Chief of Field Services by May 18, 2013, certifying the completion of intake Assessment, confirming eligibility, and documenting the names of eligible DSB-STEP Program Trainees.
- Rate per Assessment--\$300
- C. Develop Individualized Training Plan per intake assessment results for a minimum of 86 eligible DSB-STEP trainees using the DSB model. Submit letter bill to DSB Chief of Field Services by May 18, 2013, documenting the names of DSB-STEP Program Trainees for which a Training Plan has been completed.
- Rate per Individualized Training Plan--\$200.00
- D. Provide one or more (3 to 5 week) Training Modules, including equipment, materials, and supplies, on-campus or across the state, to a minimum of 86 eligible DSB-STEP Program Trainees to improve or eliminate skill deficits per established Training Plan. Submit letter bill, along with summary report, to DSB Chief of Field Services identifying trainee participants per billing by June 15, 2013.
- Rate per Training Module--\$3,000.00
- E. Conduct Exit Assessment of a minimum of 86 eligible DSB-STEP Program Trainees, using the DSB model, to determine improvement in individual independent living skills either on-campus or in local communities across the state by June 15, 2013. The evaluation of progress is to include the MSU on-line exit evaluation which is to be completed on all participants who completed an application and who had a MSU Intake assessment completed. Submit letter bill to DSB Chief of Field Services by June 15, 2013, identifying Trainees, per billing, for which Exit Assessment had been conducted.
- Rate per Exit Assessment--\$300.00

- F. Complete Evaluation Report for all eligible DSB-STEP Program Trainees, per DSB model, by June 30, 2013, and submit to DSB Chief of Field Services along with letter bill requesting payment for report per agreed rate. The Evaluation Report will include all the Data elements needed for completion of the 7-OB form. WSB will collaborate with Division of Services for the Blind as needed on the completion of the 7-OB report.
- Rate for Evaluation Report--\$2,800.00

DSB in-house activities. In addition to IL services provided by DSB-STEP, DSB in-house staff conduct outreach efforts to identify potential referrals for the IL program. For example, itinerant rehabilitation teachers participate in a range of public awareness activities including conducting informational workshops and presenting at professional and community organizations throughout the state. A summary of FFY 2013 outreach and collaborative efforts is reported in the “narrative section” of the RSA 7-OB and included in this report (see Appendix D). DSB staff also continue to be involved with peer support groups in different regions of the state. These informal support groups were established to allow older people experiencing blindness or vision impairment to share with others their experiences and coping strategies in dealing with vision loss. Because vision loss is a low prevalence disability, many older people may not know another person with a visual impairment; therefore, these peer support networks provide a valuable link to others with similar experiences. Because of the rural nature of Arkansas, it is often difficult for people to obtain transportation to peer group meetings. DSB maintains a toll free number which allows consumers to make inquiries and obtain information and referral services without having to incur personal expense.

OIB Program Management Staff (DSB and DSB-STEP)

Ms. Lou Tally served as DSB's Older Blind Project Manager, followed by Ms. Mary Douglas. During FFY 2013 both reported to Ms. Christy Lamas, Field Services Administrator. Jointly their responsibilities included annual reporting of program activities to Rehabilitation Services Administration; overall management of program activities, including monthly meetings with DSB-STEP staff; and budget management. Dr. Janet Ford is the Older Blind Program Coordinator for the DSB-STEP administrative contract. In addition to administrative responsibilities, Dr. Ford provides the majority of itinerant services to consumers.

Advisory Committee

A 12 member Advisory Council that meets four times a year provides program guidance to the OIB program. This Council is comprised of individuals representing major consumer groups, consumers-at-large, university blindness-related programs, and disability-related agencies and organizations. Council members bring their unique perspectives and experiences to the group, thus helping ensure effective and relevant services are provided to consumers of the OIB program.

Table 3: Members of Advisory Committee for OIB Program (3/8/13)

Ms. Winter Cox, Mainstream Independent Living
Mr. Jeff Weiss, World Services for the Blind
Ms. Kathy Freeman, Area Agency on Aging
Mrs. Nola McKinney, American Council of the Blind
Mr. J.D. Hall, Library for the Blind and Physically Handicapped
Dr. Patricia Bussen Smith, UALR-Dept of Cnlg & Adult Rehab.Educ,
Retired (Chair)
Ms. Lori Raines, Dept of Human Services-Office of Long Term Care
Ms. June Richardson, VA
Ms. Lynn McAllester, Delta Resource Center
Ms. Sandra Edwards, American Council of the Blind
Mr. Shawn Smith, Arkansas Information Reading Services Director
Mr. Jimmy Sparks, NFB

Purpose of Study

The purpose of this program evaluation is to assess the impact of OIB services on the independent living functioning of consumers and the satisfaction of consumers served by the OIB program. A major focus of the report is the presentation and discussion of findings from the analyses of data (as reported by DSB-STEP staff) from pre- and post-program functional assessments of closed consumers. In addition, satisfaction and functional data from telephone interviews conducted by MSU staff with a sample of closed consumers are included in this report. The external evaluation process included the following major activities:

- Implementation of external evaluation activities, including review and revision, as needed, of data collection instruments and forms;
- Maintenance of accessible online surveys for collection of pre- and post-functional assessment data;
- Analysis and interpretation of consumer disability and demographic data to identify consumer characteristics and trends within the total population served;
- Collection, analysis, and interpretation of IL functioning data of consumers served in the OIB program;
- Collection, analysis, and interpretation of satisfaction data of consumers served in the OIB program;
- Completion of activities relating to the annual site-visit; and
- Preparation of the program evaluation report.

Organization of Report

In addition to this introductory section, this report includes method, results, and conclusion and recommendations sections. The method section provides information regarding selection of study participants, the instruments used for collection of quantitative data, the procedures used to collect data, and the techniques used for data analysis. The results and discussion section provides

aggregate data on consumer demographics for all consumers served by the OIB program in FFY 2013. In addition, consumer demographics and findings regarding consumer functioning on specific IL tasks or domains are reported for a sample of consumers closed during FFY 2013. Demographic data elements include age, gender, race, living arrangement, reported eye conditions, and reported other health conditions. Information from the August 2013 site-visit is also reported in the results section. The final section of this report provides a summary of evaluation activities, including a list of program recommendations.

MSU National Research and Training Center (NRTC) on Blindness and Low Vision staff assigned to this project included Dr. Jamie O'Mally, Assistant Research Professor and Project Director, Ms. B.J. LeJeune, Site Evaluator, and administrative support staff.

METHOD

Research Design

This study used a mixed-method research design to collect program evaluation information from a variety of sources. Information from the Independent Living Services 7-OB annual report for FFY 2013 was used to describe demographic and disability characteristics of all consumers receiving Title VII - Chapter 2 services in Arkansas. The Pre- and Post-Program Functional Capacities Assessments (see Appendix A for copies of instruments) were used to gather information from consumers closed by the DSB-STEP program. These instruments assessed consumers' IL functioning before and after delivery of services and are further described in this section. Findings from telephone surveys of closed consumers (see Appendix B for copy of instrument) were used to provide information on consumer satisfaction with services. Finally, the MSU Project Director and a Site Evaluator conducted an on-site review to gather additional program information. These sources of data are further described in the "Instruments" subsection below.

Participants

The OIB program served a total of 172 consumers in FFY 2013. Information from demographic (e.g., age, gender, race/ethnicity) and disability measures (e.g., level of visual impairment, other health conditions) are reported for these consumers. Information on demographic, disability, and functional abilities measures is also available for 67 closed consumers with matching pre- and post-functional data. Consumer satisfaction and functional information is available from telephone interviews of 33 closed consumers.

Instruments

Annual 7-OB Report (all cases served during fiscal year). All states, the District of Columbia, and territories receiving Title VII - Chapter 2 funding must submit a completed 7-OB report to RSA approximately three months after the close of each fiscal year. Information reported on the 7-OB includes funding sources and amounts, staff composition and numbers, and consumer demographic, disability, and services data. Data from the OIB 7-OB report for FFY 2013 are presented beginning on page 16 of this report.

Functional Capacities Assessments (cases closed during FFY). Both the pre- and post-program consumer assessments include questions regarding consumer demographic and disability information (e.g., age, gender, race, cause of visual impairment) similar to that reported on the annual RSA 7-OB Report. Demographic and disability data from closed cases are aggregated and compared (to assess generalizability of findings) with similar data from all cases served by the program as reported on the annual RSA 7-OB. Other sections of the pre- and post-assessments quantify consumers' performance/functioning on 33 IL skills typically addressed by rehabilitation teachers and/or orientation and mobility instructors. The 33 items measuring consumer performance are identical between the forms. Levels of consumer functioning on skills are rated by DSB-STEP service delivery staff in collaboration with the consumer. Scores from the pre- and post-program assessments are used to compute changes (loss, stable, gain) in consumers' capacity to perform tasks after receiving services.

On the online pre- and post-assessments, the 33 IL skills are listed under four headings: kitchen skills/home management; personal management; low vision and communication skills; and orientation and mobility skills. The MSU Project Director collaborated with DSB staff in implementing this format in FFY 2003 with minimal changes made over the years. The current RSA 7-OB reporting form requires that consumer functioning data be reported as a result of receiving services in four broad areas: assistive technology services; orientation and mobility services; communication skills training; and daily living skills training. Therefore, to facilitate DSB reporting on the annual 7-OB, change scores for the 33 IL skills are reported using the four RSA 7-OB service categories. Categories include:

- **Assistive Technology** (IL skills such as reading or accessing print, operating television, using distance and low vision aids)
- **Orientation and Mobility** (IL skills such as traveling safely around the home and neighborhood, using public transportation, traveling safely using sighted guide techniques, negotiating steps safely)
- **Communication Skills** (IL skills such as accessing written notes, using listening and/or recording devices, using the telephone, signing name, accessing watches/clocks)

- **Daily Living Skills (Includes Personal Management)** (IL skills such as performing hygiene tasks, sewing, matching and selecting clothing, identifying and organizing money; identifying and regulating medication, preparing meals, cleaning home)

The pre- and post-program assessment instruments also include 5 items assessing overall fitness and health of consumers. For example, consumers are assessed on their ability to hear and follow normal speech; walk different distances; walk up steps; retain simple instructions or telephone numbers; and lift, bend, stoop, and reach.

In assessing functioning, DSB-STEP staff utilize a performance level scale to measure degree of consumer difficulty in completing IL tasks:

- normal capacity/no difficulty
- diminished capacity/some difficulty
- reduced capacity/serious or great difficulty
- incapacity/cannot perform task
- unable to obtain reliable rating

In addition, staff can check “not applicable” if the task was not a part of the consumer’s individualized instructional plan. Service delivery staff meet with consumers at program entry and at program exit to complete the pre- and post-program assessment forms. In order to preserve objectivity during the post-program assessment, staff do not retain data from the pre-program assessment in case files. Pre- and post-assessment data are submitted online to MSU-NRTC research staff for matching and analyses. Findings from the functional assessment instruments are reported beginning on page 22.

Program Participant Survey (cases closed during FFY). The Program Participant Survey was developed to enable NRTC project staff to directly solicit feedback from consumers regarding their satisfaction with services and the impact services had on their IL functioning on key IL areas reported in Part VI: Program Outcomes of the RSA 7-OB report. The survey was developed by MSU-NRTC in consultation with DSB administrative staff. The Program Participant Survey was divided into four sections, as described below:

- **The first section** contained three questions which quantified respondents' level of agreement with statements related to the manner in which services were delivered (i.e., timeliness of services, expertise of service delivery staff, and quality of services). A five-point scale (strongly agree, agree, neutral, disagree, strongly disagree) was used to assess the level of agreement. Respondents were also provided opportunity to comment on each item.
- **The second section** contained four multi-part questions which focused on broad service areas typically provided by OIB programs (i.e., orientation and mobility, assistive technology, communication skills, and other activities of daily living). The Arkansas program must report outcome data on these four services in its annual 7-OB report. Respondents were first asked if they had received each service, and if they had not, was this a service they would have liked to receive. Respondents indicating they had received a service were then asked to provide feedback regarding their functioning (i.e., service had resulted in improved functioning, maintenance of functioning, or loss of functioning). Again, respondents were invited to further comment on their responses. Note that participants may not have received all four services, given that IL plans are individually developed to address consumers' particular needs and interests.
- **The third section** included only one question. Respondents were asked in comparison to their functioning before services, if they now had greater control and confidence, if there had been no change in their control and confidence, or if they now had less control and confidence in their ability to maintain their current living situations. If a consumer reported less control and confidence, he/she was asked to explain/comment.
- **The last section** included questions related to respondents' demographic and disability characteristics. Included were questions regarding age, gender, race/ethnicity, living situation, reason for visual impairment, presence of a hearing loss, and race/ethnicity. Respondents were asked if they had experienced any life-style changes in the last few months that had resulted in their becoming less independent, and in their opinion, if services had helped them remain in their home and community.

Findings from the Program Participant Survey are reported beginning on page 31.

Procedures

Information on the role and responsibilities of management and direct services staff and a description of the service delivery process was compiled from the on-site review and correspondence with administrative staff. Other on-site review activities included meeting with DSB and WSB administrative staff and service delivery staff, reviewing case files, and observing DSB-STEP staff providing IL services to consumers.

Consumer functional abilities were evaluated using data from the Pre- and Post-Program Functional Capacities Assessments. Pre-program assessment data completed by DSB-STEP service delivery staff at the time the consumer entered the program was matched with post-program assessment data completed at the time the consumer exited the program. This allowed a comparison to be made of consumer functional abilities before and after participation in the program and the resulting determination of any change in functioning (i.e., gain, maintenance, loss) following services. Additional data regarding IL functioning and satisfaction of consumers following service delivery were collected using the Program Participant Survey—NRTC project staff interviews of consumers closed from the program after receiving services.

Information regarding funding sources and amounts, staff composition and numbers, and consumer demographic, disability, and services data was compiled from the FFY 2013 7-OB report.

Data Analysis

Descriptive statistics were used to summarize data from the DSB's annual RSA 7-OB report, Pre- and Post-Program Functional Capacities Assessments, and Program Participant Surveys. Common descriptive statistics included frequencies, percentages, means, etc. Percentages of consumers functioning at the different performance levels at pre and post were calculated and are included in the report.

RESULTS

Findings from four major data sources: the program's RSA-7-OB report, pre- and post-functional assessments, telephone interviews with program participants, and an on-site program review are included in this section.

I. Annual 7-OB Report

In FFY 2013 (October 1, 2012 through September 30, 2013), the OIB program served 172 consumers.

Age and Gender. Fifty-two percent ($n = 89$) of all consumers served were age 75 and over. Most were female (67%, $n = 115$).

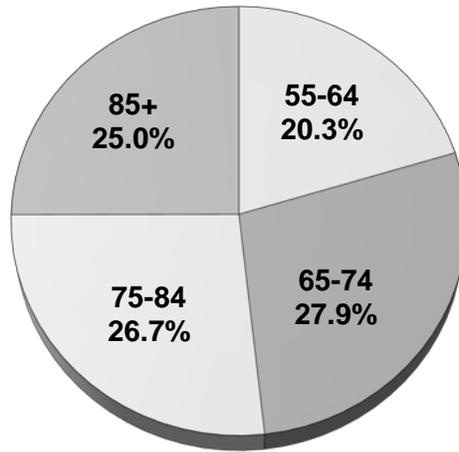
Race/ethnicity. Consumers are asked to self-report their race and ethnicity. The majority of consumers reported being White not Hispanic/Latino (76.1%, $n = 131$) or Black/African American not Hispanic/Latino (23.3%, $n = 40$). One individual reported being Hispanic/Latino of any race. No other races or ethnic groups were reported. (Data from the 2008 ACS Census data indicate that among Arkansans 55 and older, 87.3% are White, 10.1% are African American, 0.4% are Native American, 0.5% are Asian American, 1.1% are Hispanic, and 0.6% are of another race or ethnicity.)

Living situation. The vast majority of consumers lived in private residences ($n = 147$, 85.4%), with 14.6% living in either senior living/retirement community settings ($n = 11$), in assisted living facilities ($n = 8$), or in nursing homes or long-term care facilities ($n = 6$).

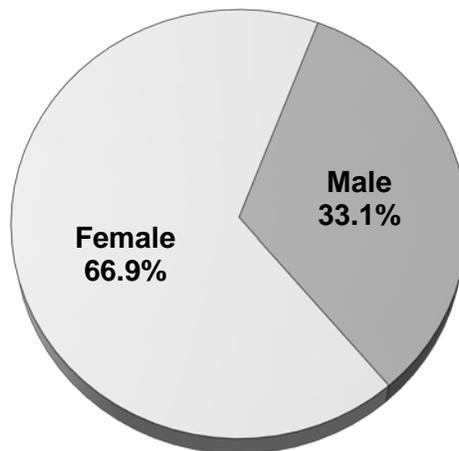
Visual impairment. Approximately 73% ($n = 126$) were legally blind (includes totally blind), and the number one cause of visual impairment (48%, $n = 82$) was macular degeneration, followed by cataracts (19%, $n = 32$) and glaucoma (16%, $n = 27$).

Demographic and disability information on all consumers are provided in the following figures. Please note that due to rounding, or when multiple responses were allowed, percentages may not add up to exactly 100%.

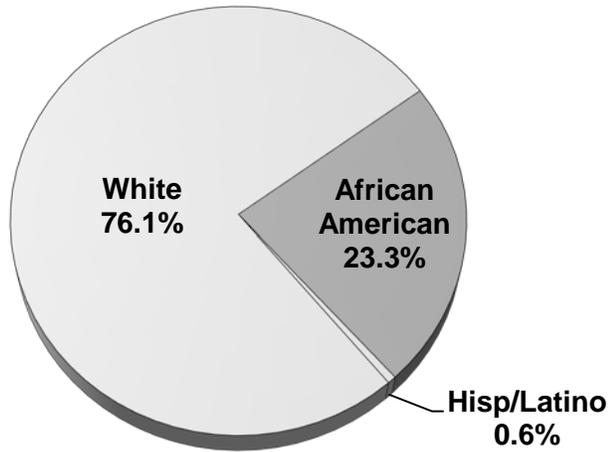
Age Categories



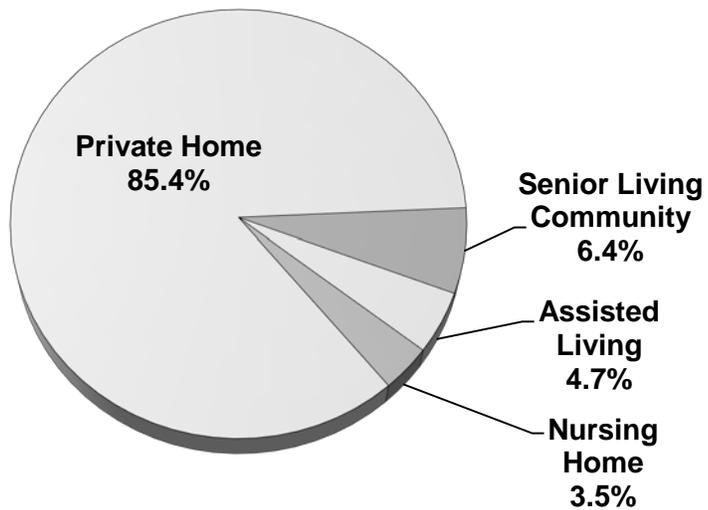
Gender



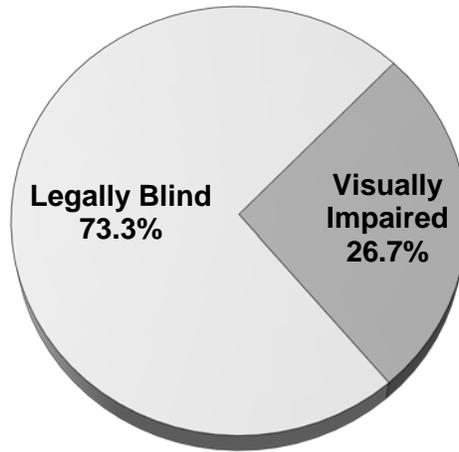
Race/Ethnicity



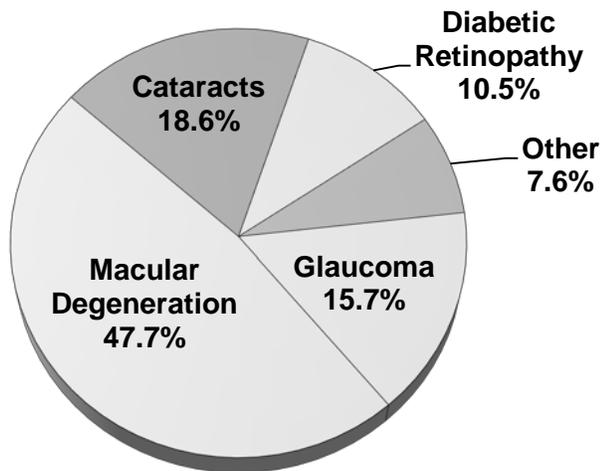
Type of Residence



Degree of Visual Impairment

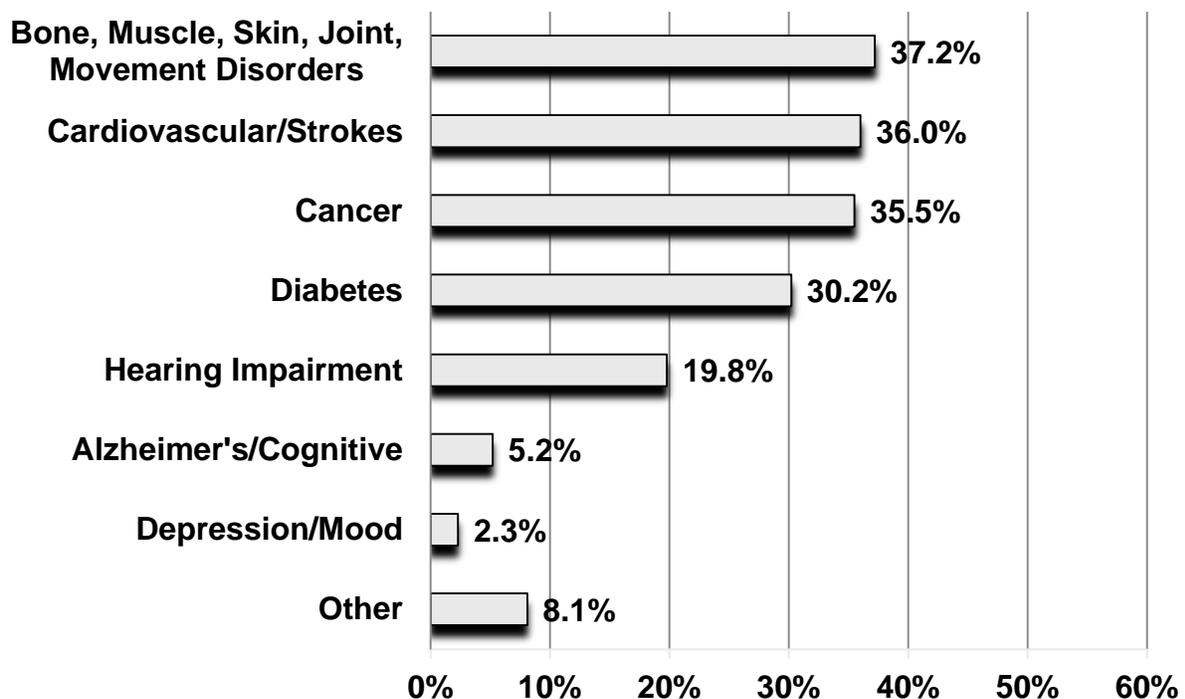


Major Cause of Visual Impairment



Non-visual health conditions. The following figure presents the number of consumers reporting health conditions in addition to visual impairment. The most frequently reported nonvisual conditions were bone, muscle, skin, joint, and movement disorders ($n = 64$, 37.2%), closely followed by cardiovascular disease and strokes ($n = 62$, 36%), cancer ($n = 61$, 35.5%), diabetes ($n = 52$, 30.2%), and hearing impairment ($n = 34$, 19.8%). Approximately 16% of consumers had conditions including Alzheimer's/cognitive ($n = 9$), depression and mood ($n = 4$) or other age-related health conditions not included in the major categories on the RSA 7-OB ($n = 14$).

Non-Visual Health Conditions



Source of referral. The majority of referrals (51%) were from eye care providers ($n = 55$, 32%) or the state VR agency ($n = 32$, 19%).

Staffing. Program FTE positions reported in the FFY 2013 7-OB report included 1.80 administrative and support staff (.05 DSB; 1.75 DSB-STEP) and 2.00 direct service staff (DSB-STE) for a total of 3.80 FTEs.

Funding. For FFY 2013, total federal grant money available was \$579,203. This sum included \$295,505 Title VII-Chapter 2 Federal grant award and \$283,698 federal carryover from the previous year. The program expended a total of \$561,043: \$283,698 from Title VII-Chapter 2, \$195,612 from State sources, and \$81,733 from in-kind sources.

Services. Table 4 lists types of services and the number and percentages of consumers receiving each service. A total of 172 consumers (non-duplicated count) received one or more of the following services. In comparison, 576 consumers received one or more of these services in FFY 2012.

Table 4: Services by Number and Percentage Receiving

	<u>Number</u>	<u>Percentage</u>
<i>Clinical/functional vision assessment and services</i>		
Vision screening	13	0.07%
Surgical or therapeutic treatment	1	0.01%
<i>Assistive technology devices and services</i>		
Provision of assistive technology devices/aids	112	65%
Provision of assistive technology services	138	80.2%
<i>Independent Living/adjustment training and services</i>		
Orientation and Mobility training	38	22.1%
Communication skills	25	14.5%
Daily living skills	40	23.3%
Supportive services	4	0.02%
Advocacy training and support networks	26	15.1%
Counseling	3	0.02%
Information, referral and community integration	110	64%
Other IL services	6	0.03%
<i>Community Awareness: Events & Activities</i>		
Information and Referral	230	134%
Community Awareness: Events/Activities	40	23.3%

Program outcomes/performance measures. All consumers receiving the following services during FFY 2013 were reported as either gaining or maintaining functioning in key independent living outcomes as a result of services at the time of closure: O&M services ($n = 38$), communication skills training ($n = 25$), daily living skills ($n = 40$). Of those who received assistive technology services and training ($n = 138$), 84.8% ($n = 117$) either maintained or improved functional abilities that were previously lost or diminished as a result of vision loss. Note that a large number of consumers could still be receiving services at the close of the reporting period and that IL functioning is not assessed until consumers' cases are closed from the OIB program.

II. Pre- & Post-Functional Assessments (Closed Cases Only)

DSB-STEP staff submitted pre- and post-assessment data for 81 closed cases. Of the 81 matched cases submitted, both pre and post data for 14 cases were entered into the online system on the same day. In order to improve integrity of the data, it is critical that pre and post data are entered into the system *separately* (at the time of intake and at the time of closure). As a result of failure to follow established data entry procedures to ensure data integrity, those 14 cases have been excluded, resulting in a final sample of 67 cases used in the following analyses.

Age, gender, living situation. The mean age of consumers was 72 years. The majority were female ($n = 40$, 60.6%), and 39.4% were male ($n = 26$); one response was not reported. About half (51%) lived alone, and half lived with others (e.g., family, spouse, caretaker). In addition, the majority lived in private residences ($n = 61$, 92%). The remaining consumers were reported as living in senior living/retirement communities ($n = 4$, 6%), and nursing home/long term care facility ($n = 1$). The living situation for one individual was not reported. When compared with all consumers served by the program as reported in the RSA 7-OB report, a larger percentage of individuals in this group resided in private residences (92% vs. 85%).

Race/ethnicity. Approximately 83.6% were White, non-Hispanic; and 14.9% were African American, non-Hispanic. One individual was Hispanic/Latino of any race; and no other races/ethnicities were reported. Racial background differs from that reported in the 7-OB report of all consumers served: 76.2% were White, non-Hispanic; and 23.3% were African American, non-Hispanic.

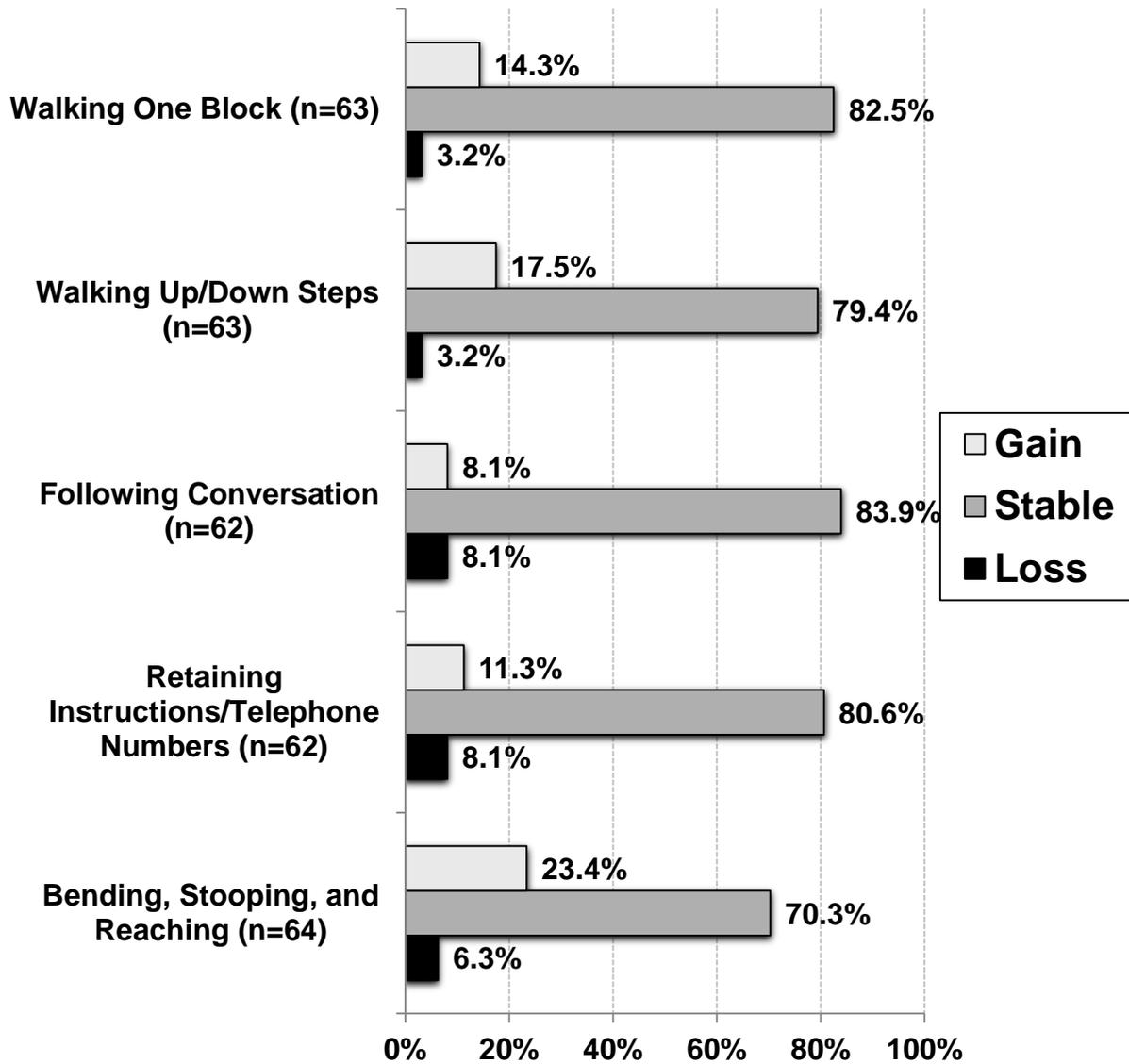
Visual impairment. Half of the individuals in this group were legally blind, of whom 17 (50%) had no light perception or light perception only. In comparison, 73.3% of all consumers served were legally blind. About one third (31.3%) of the individuals in this group reported age-related macular degeneration—the leading cause of vision impairment among older persons in the United States—as their primary visual diagnosis. When compared to all consumers served by the program, this group had a much larger percentage of individuals attributing vision loss to other causes (53.7% vs. 7.6%), with comparatively lower rates attributed to macular degeneration (31.3% vs. 47.7%), diabetic retinopathy (7.5% vs. 10.5%), cataracts (4.5% vs. 18.6%) or glaucoma (3% vs. 15.7%).

Other health conditions. Individuals in this group also reported having a number of other impairments/health conditions. The number one condition was diabetes (20.9%) followed by cardiovascular disease/strokes (16.4%); Alzheimer's/cognitive impairments (16.4%); hearing impairments (11.9%); bone, muscle, skin, joint, movement disorders (9%); cancer (6%), and depression/mood disorders (1.5%). In comparison to the total group of consumers served by the program, the number one reported health condition was bone, muscle, skin, joint, movement disorders (37.2%); followed closely by cardiovascular disease/strokes (36.0%); cancer (35.5%), diabetes (30.2%); hearing impairment (19.8%); Alzheimer's/cognitive impairments (5.2%); and depression/mood disorders (2.3%).

General health. There are a number of questions in the pre- and post-program instruments that can be used to better understand the overall health and fitness of consumers served in the DSB-STEP program. These questions measure consumer functioning levels on several tasks. The figure on the following page presents the percentages of consumers who improved, declined, or remained stable in their ability to perform these fitness/health activities from pre- to post-assessment. Although improvement in general health areas may be related to intervention of rehabilitation teachers, such as training in orientation and mobility and low vision services, changes can also be the result of changes in health of consumers during the time they receive services.

Across all measures, the vast majority (94.3%) of consumers maintained or improved their ability to perform health-related activities after receiving services. Losses for some consumers were reported in all areas with the greatest losses in following conversation (8.1%) and retaining instructions and phone numbers (8.1%). The greatest gain was in tasks like bending, stooping, and reaching up (23.4%).

General Health/Fitness



Consumer Functional Outcomes

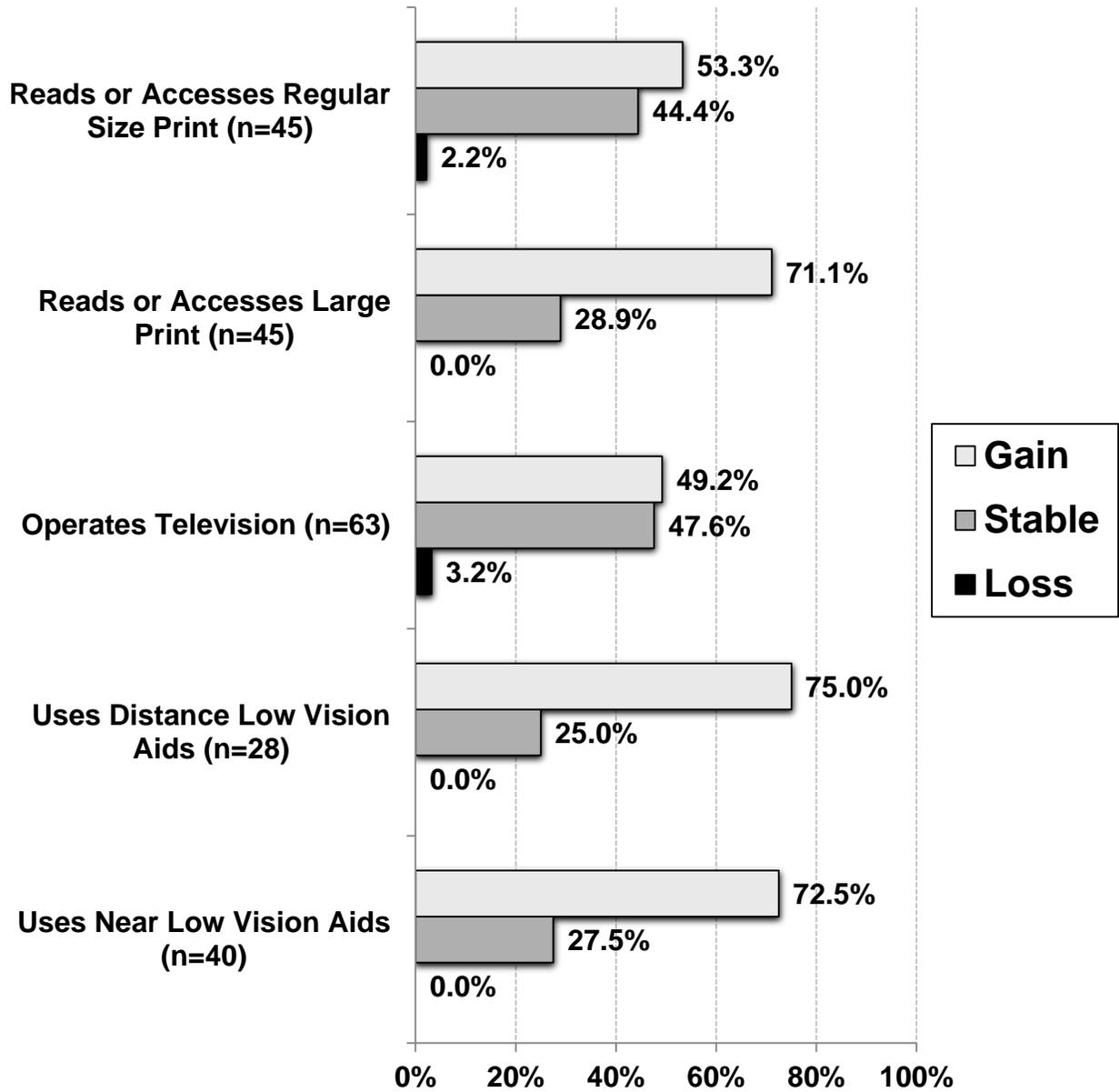
The following four figures show the percentages of people who report more difficulty (loss), same difficulty (stable), and less difficulty (gain) in the performance of independent living tasks measured in the pre- and post-program assessments. With respect to interpreting findings, it is important to understand the potential for positive changes in the lives of these individuals as the result of minimal gains. Williams (1984) uses the term “small gains” to characterize these changes and reports that these small gains may be profoundly important in the life of the individual. For example, the ability to cross the street to get the mail, while a modest task, may be very important for a consumer if she or he had not previously been able to get to the mailbox. If asked, a consumer would probably indicate that this gain substantially improved the quality of her or his life.

There are a variety of reasons why IL consumers would demonstrate stability or loss even after receiving IL services. Given the age of many of the consumers who receive these services, declining health or reduced vision could sometimes be expected. As a result, their performance on independent living tasks could decline as well. The concept of stable function is slightly more complicated. If an individual’s health or vision is declining, and rehabilitation activities serve to improve functioning, the net response may appear to be no change. However, without IL services, there would have been decline. Other people may be performing at a high level or the level at which they choose to function, and therefore, no change would be expected.

For purposes of this analysis, independent living tasks are clustered into four broad categories: Assistive Technology, Orientation and Mobility, Communication Skills, and Daily Living Skills (includes Personal Management). The percentages of consumers who lost, maintained, or gained functioning on tasks within each category are provided in the respective figures.

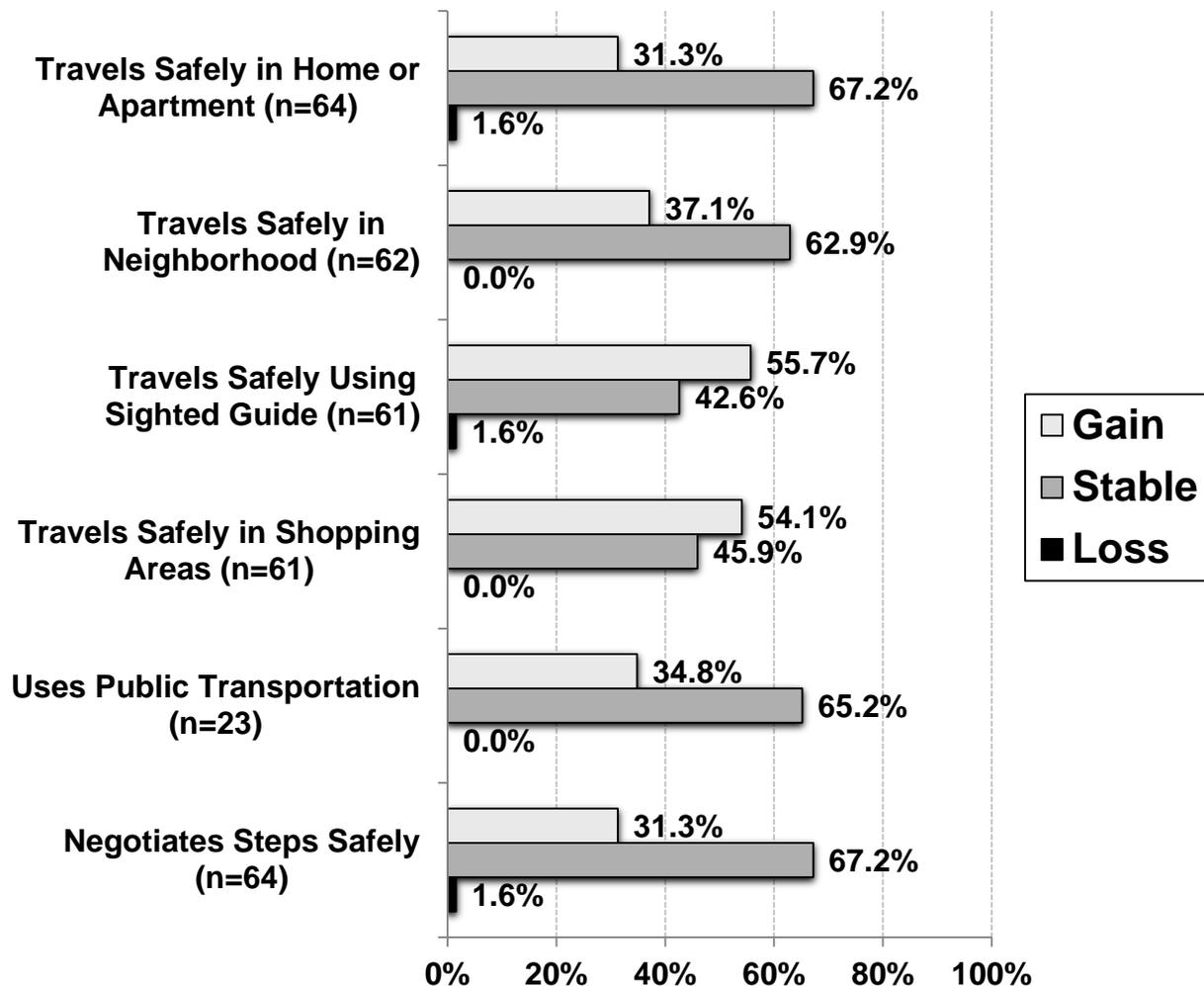
Assistive technology. Across all five measures, nearly all consumers (99%) demonstrated an increased (64%) or sustained ability (35%) to use assistive technology. Greatest gains were in using distance low vision aids (75%), and the only areas of loss occurred in ability to operate a television (3.2%) and reading or accessing regular and large size print (2.2%). The following figure includes loss, stable, and gain information for each of the tasks assessed.

Assistive Technology Services



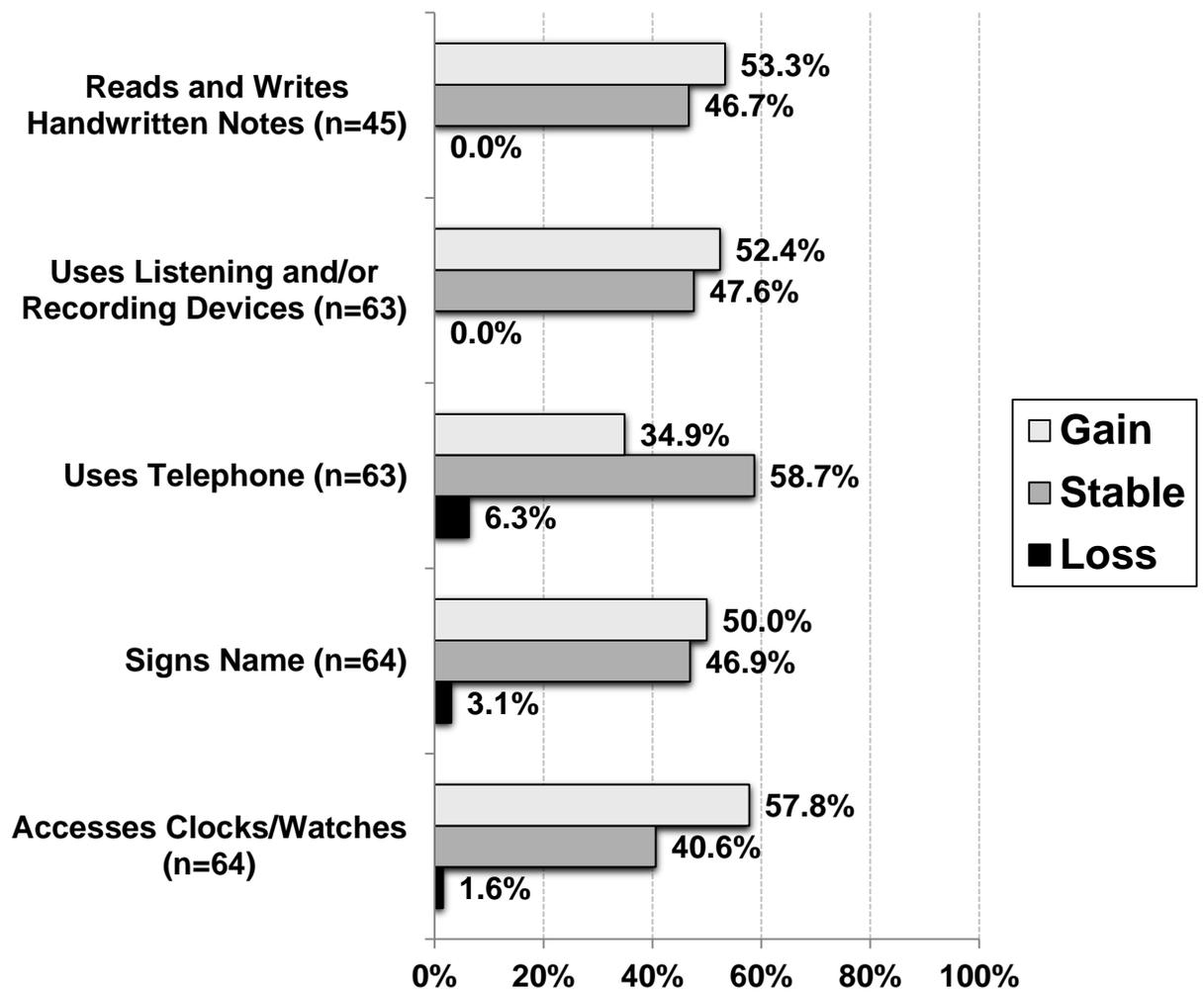
Orientation and mobility. Although IL consumers do not always receive services from orientation and mobility specialists, their pattern of mobility outcomes is encouraging. Across the six measures, less than 1% of consumers (.9%) demonstrated decreased capacity (loss); 58% demonstrated a sustained capacity, and 41% demonstrated increased capacity (gain) in skills to perform orientation and mobility tasks. Although small percentages of declines occurred, those declines were for complex, physical activities. For example, 1.6% were less able to negotiate steps safely. Consumers experienced their greatest gains in their ability to travel safely using a sighted guide (55.7%) and in their travels in shopping areas (54.1%). Each of the six orientation and mobility tasks is presented in the following figure.

Orientation & Mobility Services



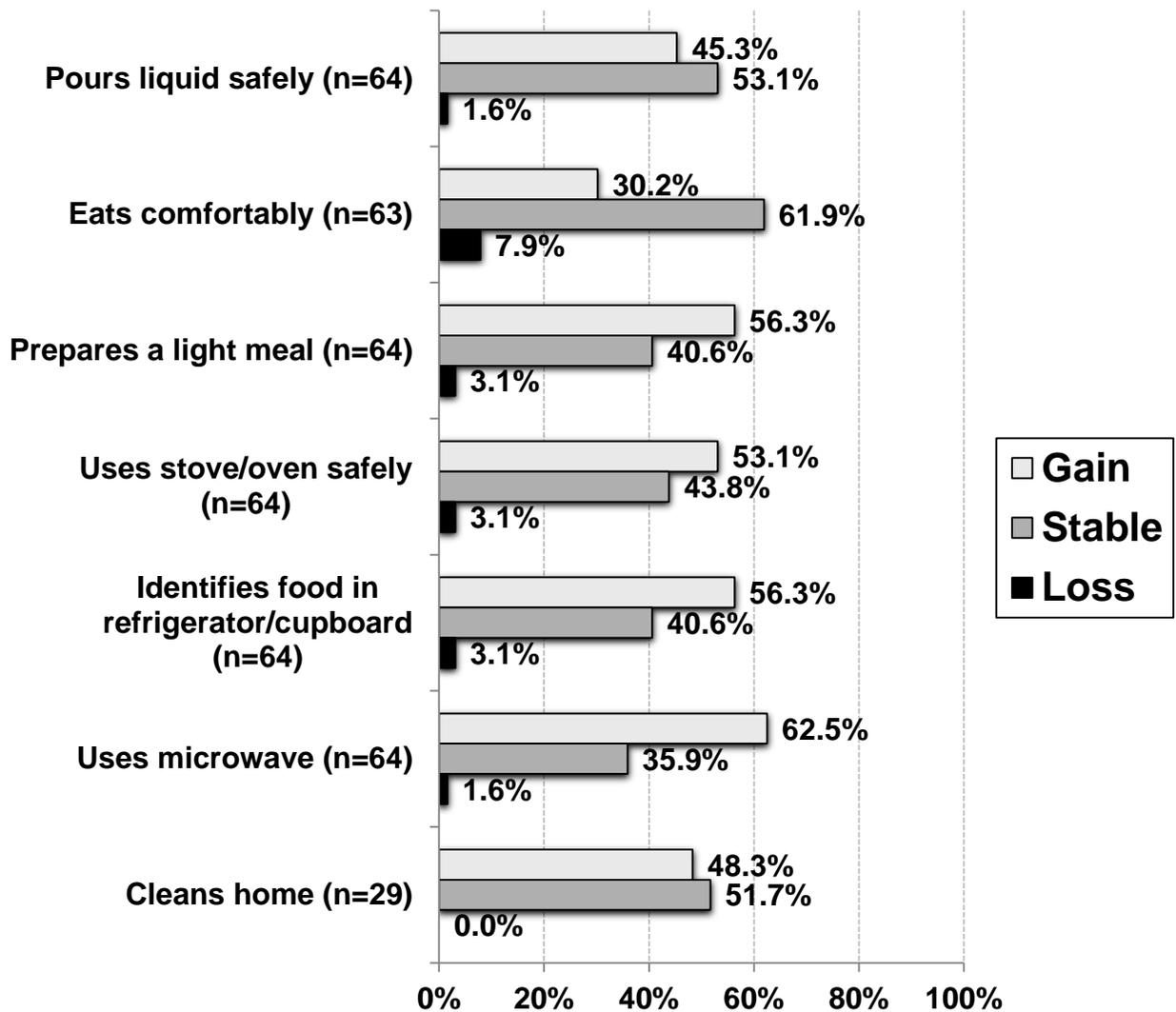
Communication skills. The following figure shows the percentage of consumers who lost, maintained, or gained functioning for the 5 communication tasks. Across the five measures, only 2.3% of consumers lost skills, 48.2% of consumers maintained, and 49.5% gained skills in performing communication tasks. A review of specific communications tasks indicates that consumers' greatest gains occurred in their ability to check the time using clocks or watches (57.8%) and their ability to read and write handwritten notes (53.3%). The ability to use a telephone was the greatest area of loss, with 6.3% of consumers experiencing a decrease in this skill.

Communication Skills Training

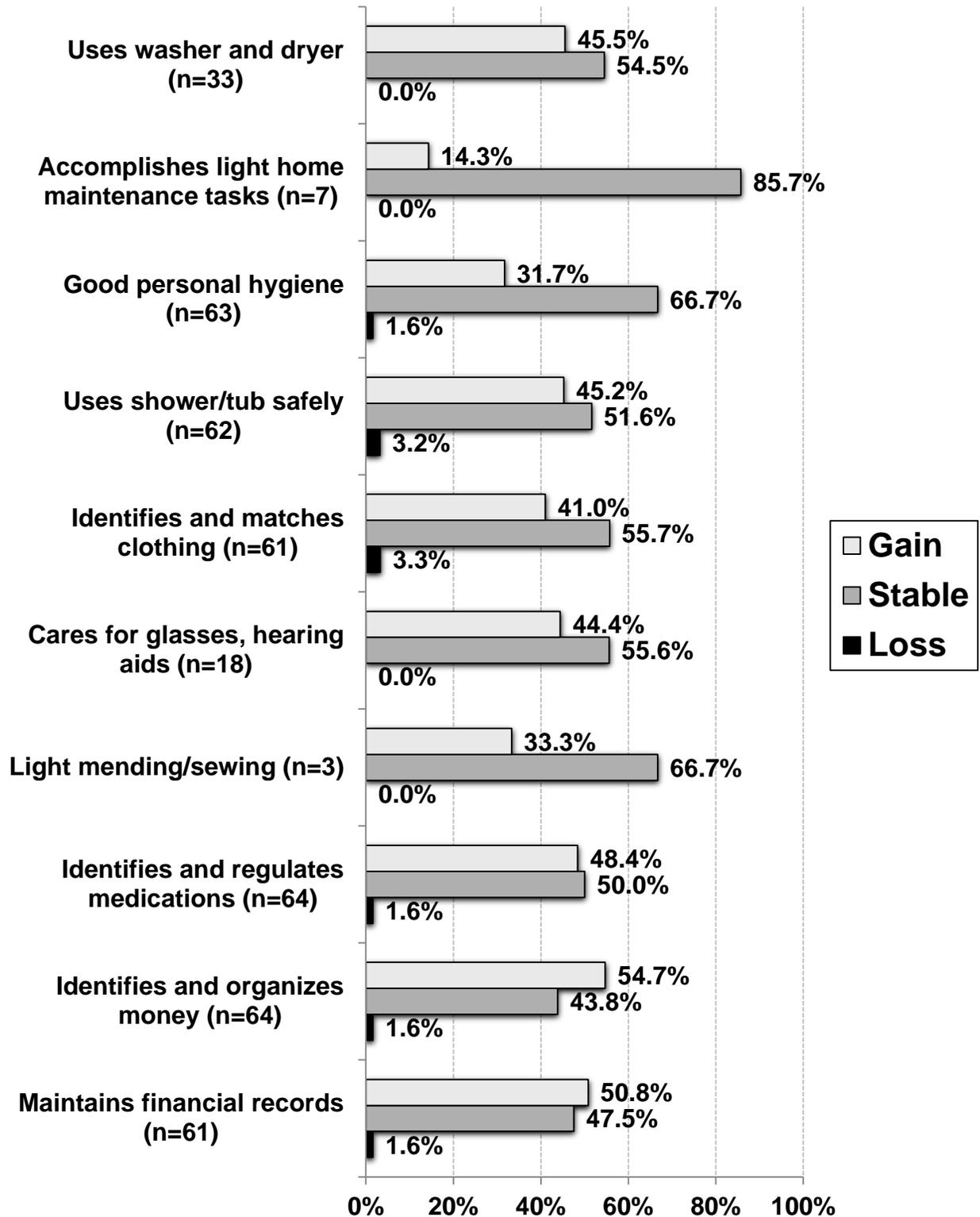


Daily living skills. The following figure shows the percentage of consumers who lost, maintained, or gained functioning for the 17 daily living/personal management tasks. Overall, only about 2.5% of consumers lost skills, 50% of consumers maintained, and 47.5% gained skills in performing daily living/personal management tasks. A review of specific tasks indicates that consumers' greatest gains occurred in using a microwave (62.5%), preparing a light meal (56.3%), identifying food in a refrigerator or cupboard (56.3%), and identifying and organizing money (54.7%). The biggest loss of ability occurred in eating comfortably (7.9%).

Daily Living Skills Training



Daily Living Skills (2)



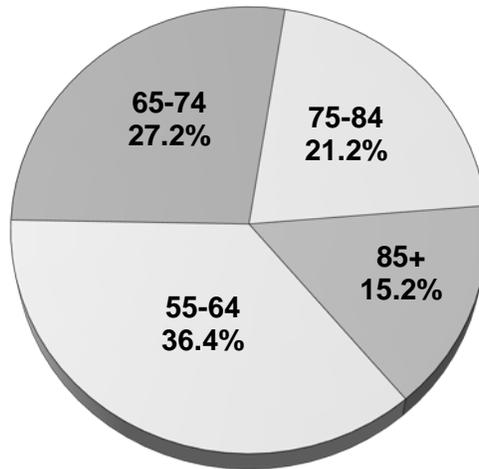
III. Interviews with Consumers (Program Participant Survey)

DSB-STEP project staff provided MSU-NRTC project staff with contact information for consumers closed during the fiscal year and to alert consumers that an interviewer from MSU would be calling them regarding services they had received. Information regarding 86 closed consumers were provided mid-August 2013. MSU project staff attempted to contact 63 of the 86 consumers. No attempts were made to contact the remaining 23 consumers for a number of reasons, e.g. DSB-STEP staff indicated that the consumer no longer had a working telephone number, consumer moved with no forwarding contact information, consumer deceased, consumer moved to nursing home. Telephone interviews of consumers were conducted over a 1 month period beginning in late August 2013. Attempts were made to contact each consumer on at least three occasions. Telephone calls were made at different times of the day and on week-ends. Interviewers were able to speak with 39 individuals; 33 consented to the interview, for a response rate of 84.6% among those individuals contacted.

Data on demographic and disability characteristics of survey participants and their perceptions regarding the manner in which services were provided (timeliness, expertise of teacher, quality of services) and the impact of services on their IL functioning are provided in the following figures and narrative. Please note that due to rounding, or when multiple responses were allowed, percentages may not add up to exactly 100%.

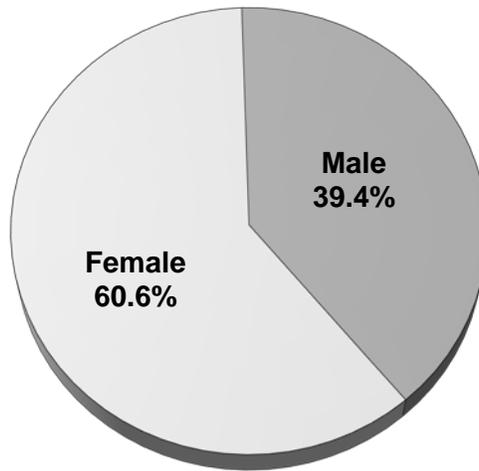
Survey Respondents: Demographic/Disability Characteristics

Age



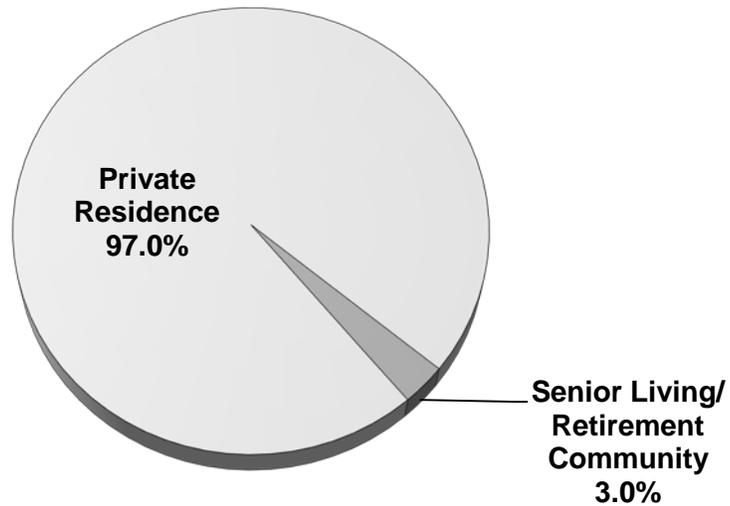
Age. The average age of respondents was 71 years, with ages ranging from 55 to 94 years. More than one third of the respondents (36.4%) were between 55 and 64 years old; 27.2% were between 65 and 74 years old, 21.2% percent were between the ages of 75 and 84, and the smallest percentage of respondents (15.2%) were 85 years old or older. While not captured in this data, Arkansas's 7-OB Report indicated that 51% of all consumers served were age 75 and older—a higher percentage than reported by survey participants in this age range.

Gender



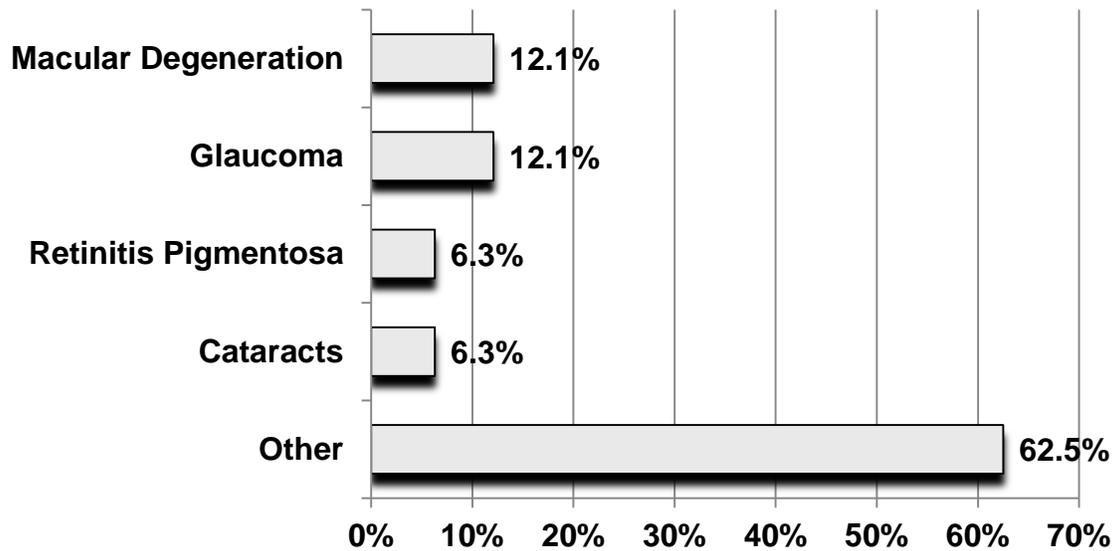
Gender. Approximately 39.4% of survey respondents were males and 60.6% were females. Data from the annual 7-OB report indicated that 67% of consumers served during the fiscal year were female—which is slightly higher than the percentage of females surveyed.

Living Arrangement



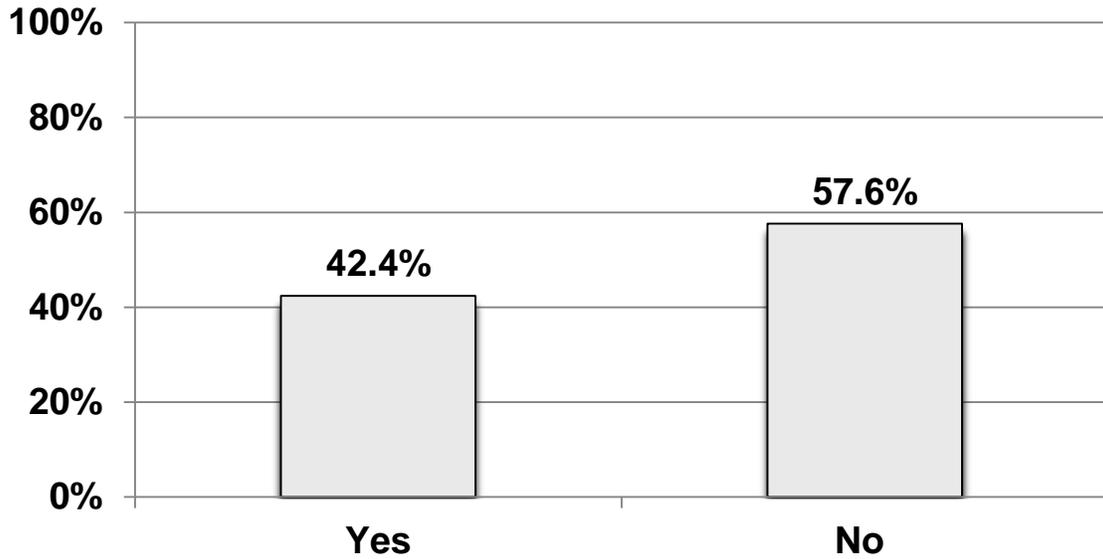
Living arrangement. Of the 33 respondents, all but one (97%) reported living in a private residence (e.g., house or apartment). The respondent that did not live in a private residence was living in a senior living/retirement community.

Cause of Vision Loss



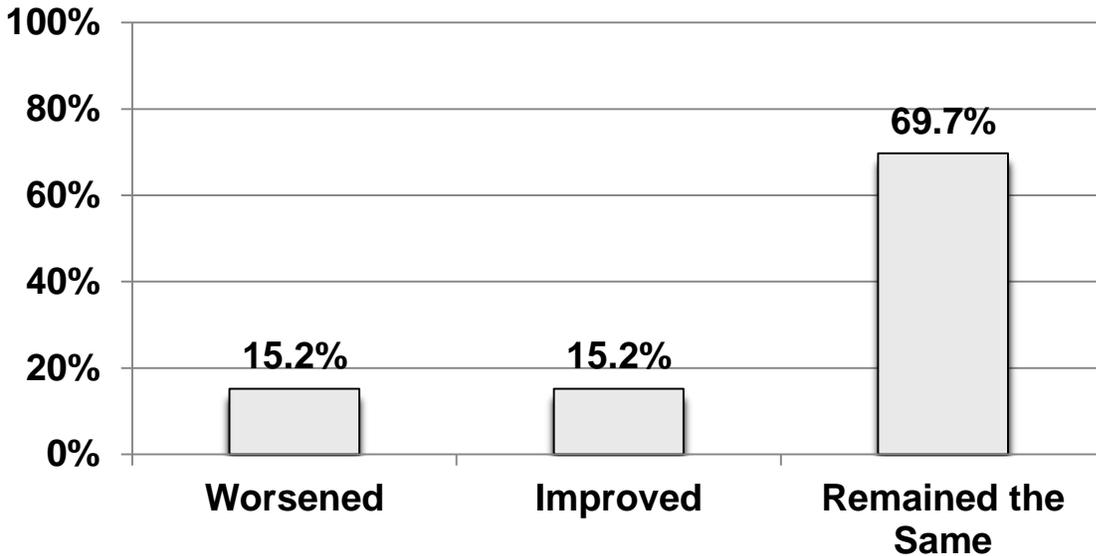
Primary cause of vision loss. Despite the fact that macular degeneration is the leading cause of vision impairment among older adults in the United States (Lighthouse International, 2013), only 12.1% ($n = 4$) respondents attributed their vision loss to macular degeneration. Other causes of vision loss reported by respondents were glaucoma (12.1%), cataracts (6.3%), and retinitis pigmentosa (6.3%). Most respondents (62.5%) attributed their vision loss to other causes not listed, including detached retina, head trauma, and nerve damage, or to multiple factors (e.g. glaucoma, cataracts, and macular degeneration combined).

Hearing Loss



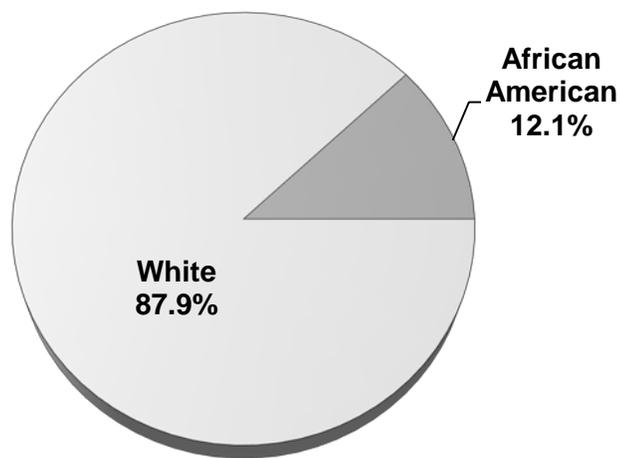
Prevalence of hearing loss. Less than half of respondents reported some degree of hearing loss (42.4%). The severity of hearing loss was rated as severe by the majority of respondents (61.8%), 8.8% rated the loss as mild, and 29.4% rated the loss as moderate.

Overall Health



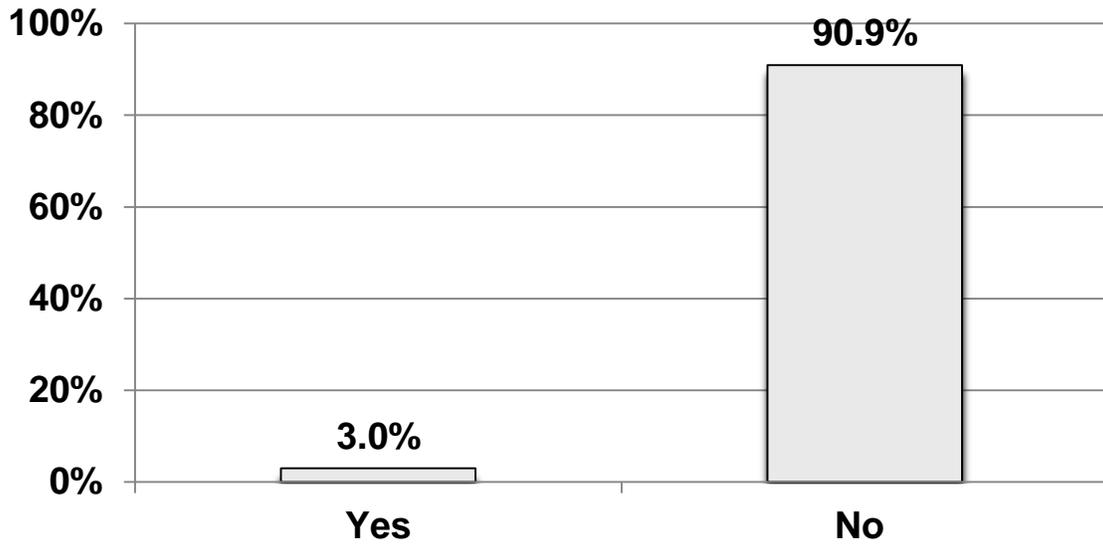
Overall health over past year. Participants were asked to indicate whether their overall health had worsened, improved, or remained the same over the past year. Five of the respondents (15.2%) reported that their health had worsened over the past year, and five (15.2%) reported their health had improved; however, a majority (69.7%, $n = 23$) indicated that their health had remained the same over the past year.

Race



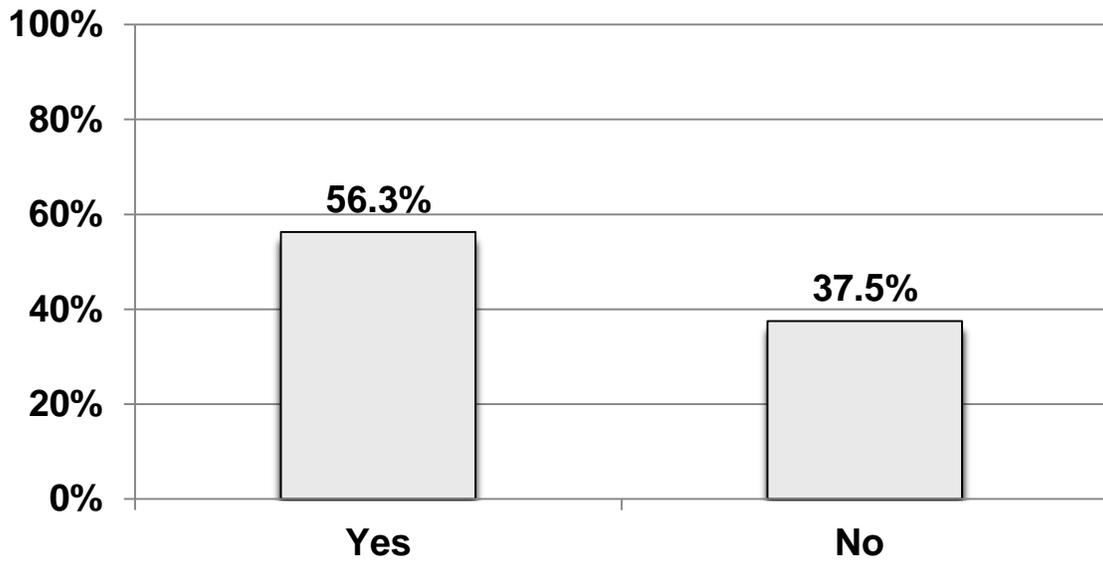
Race and ethnic background. The majority (87.9%) of the 33 responding participants indicated that they were White, and 12.1% reported as Black or African American. No other categories of race or ethnicity were indicated by the respondents. In comparison to all consumers served by the program, a larger percentage of Whites were surveyed (87.9% vs. 76%) and a smaller number of Blacks were surveyed (12.1% vs. 23%).

Changes in Living Situation



Changes in living situation. Of the 33 respondents, only one individual indicated that they had recently experienced a change in living situation that resulted in becoming less independent. Three respondents (6.1%) said they weren't sure if changes had occurred in their living situations that resulted in them becoming less independent.

Helped to Remain in Home

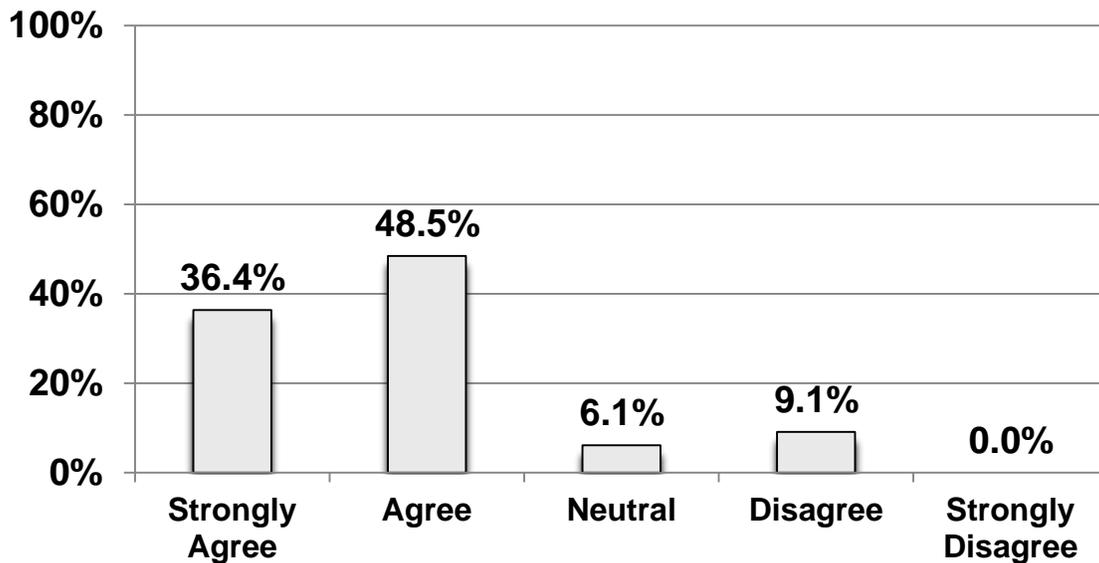


Services helped to remain in home. Of the 33 respondents, 18 (56.3%) indicated that the services they received had helped them to remain in their home or community. Two participants were unsure and one participant did not respond to the question.

Survey Respondents: Manner in Which Services Were Provided

Respondents were asked three questions regarding the manner in which services were provided: timeliness of services, expertise of the service provider, and quality of the program.

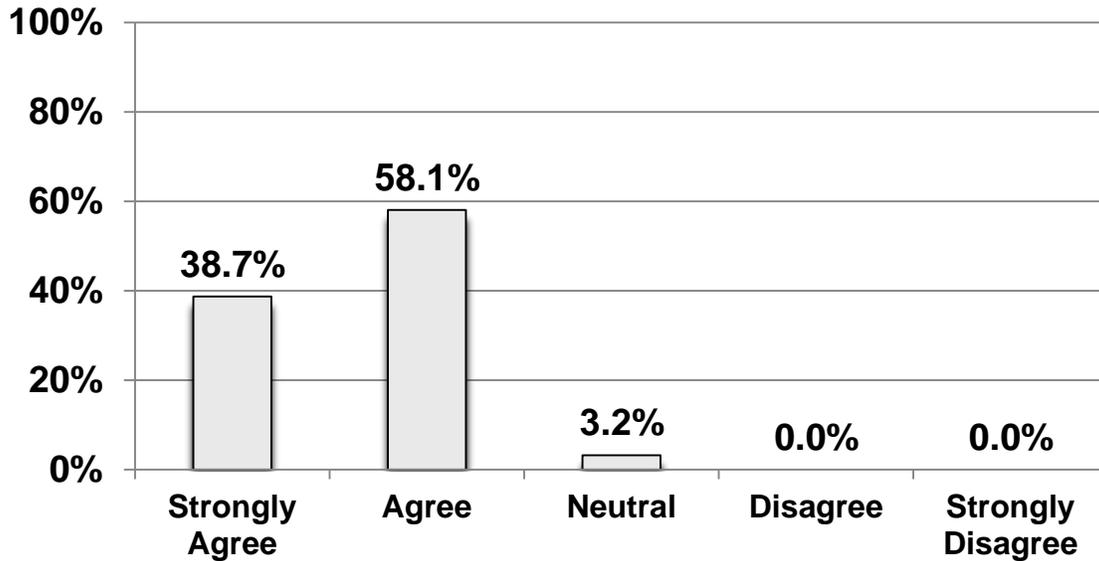
Timeliness of Services



Services were provided in a timely manner.

Participants were asked to rate their level of agreement with the above statement. The majority of respondents (84.8%) agreed or strongly agreed that services were provided in a timely fashion. Three respondents disagreed with this statement, with one individual indicating that it took a very long time to receive a Ruby.

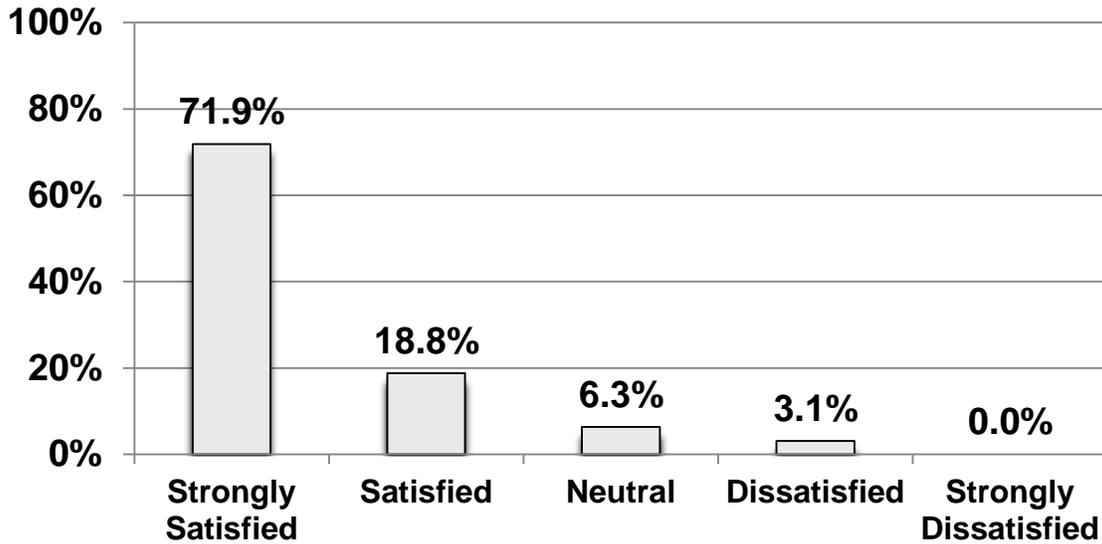
Expertise of Teacher/Instructor



Teacher/instructor was familiar with techniques and aids used by blind and visually impaired individuals.

Participants were asked to rate their level of agreement with the above statement. Overall, 96.8% of respondents agreed (58.1%) or strongly agreed (38.7%) that their teacher was familiar with techniques and aids used by blind and visually impaired individuals. One participant reported being neutral in responding to the question, and no one disagreed or strongly disagreed with the statement.

Quality of Services



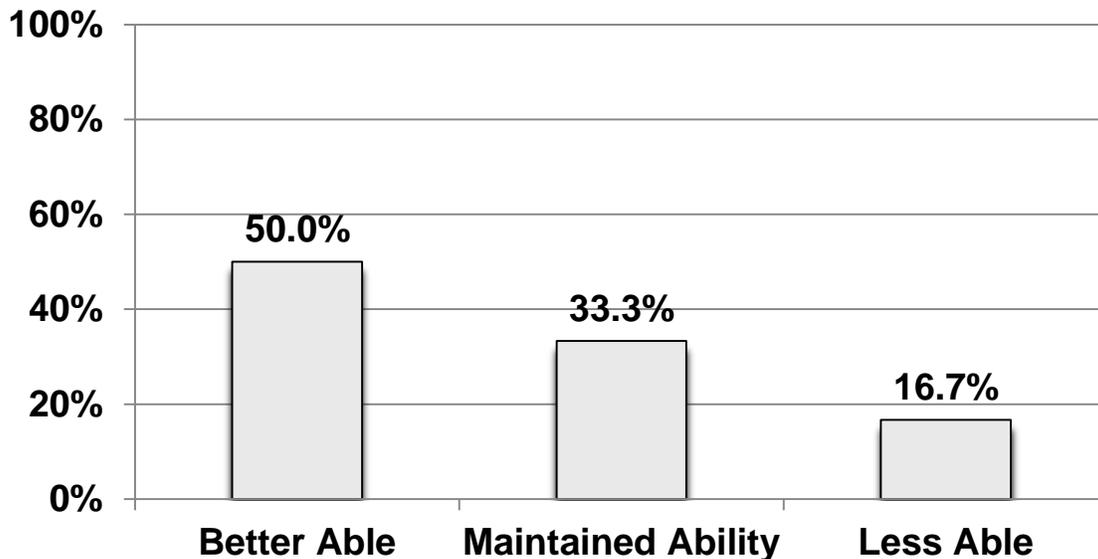
How satisfied were you with the quality of the services you received?

Participants were asked to rate their level of satisfaction with the quality of services received. Overall, 90.6% of respondents were either strongly satisfied (71.9%) or satisfied (18.8) with the quality of services received. Two individuals chose to remain neutral in answering the question. One respondent was dissatisfied with the quality of services, commenting that although he/she received an iPad, no assistance was provided to receive a Ruby. One respondent declined to answer and none of the respondents were strongly dissatisfied with the quality of services.

Survey Respondents: IL Functioning Following Services

Consumers were asked to provide feedback regarding their experiences receiving services in four broad areas: orientation and mobility/travel services, assistive technology services, communication skills training, and daily living skills training.

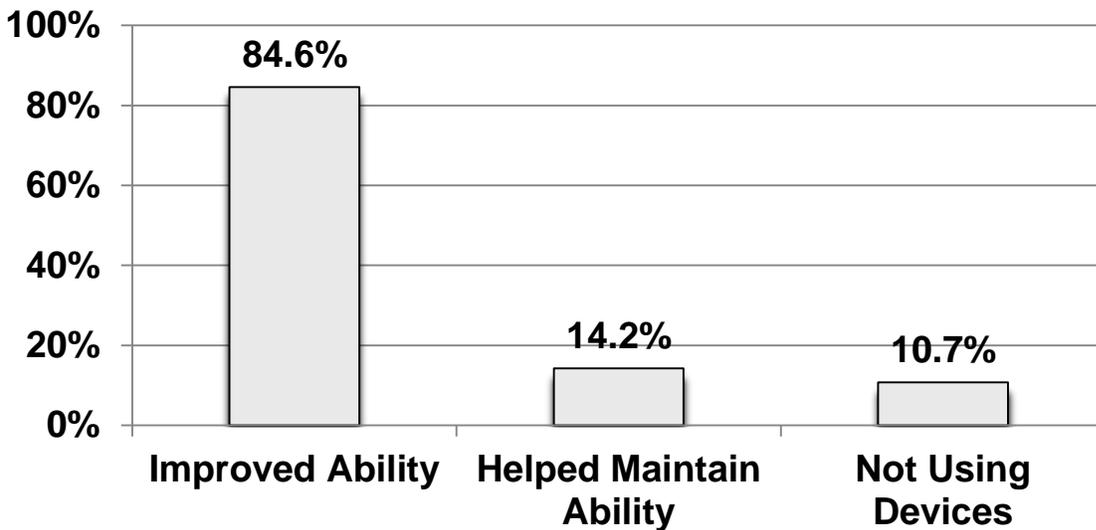
Travel Functioning



Participants were first asked whether they had received services to help them travel more safely and efficiently in their home and/or community. Twelve (36.3%) of the 33 respondents stated that they had received these services. Four (19%) of the 21 respondents who had not received travel services indicated that they would have liked to have received these services as part of their program. In responding retrospectively, consumers may have not received a service for different reasons--he/she may have originally refused the service, may have experienced decreased health and/or vision after case closure, etc.

Regarding those respondents who had received services, six respondents (50%) reported that they were now better able to travel independently in their home and/or community; four individuals had maintained their ability. Two people reported being less able to travel in their home and/or community after receiving services, with one commenting that he/she did not get the chance to practice travel outside and needed assistance in this area.

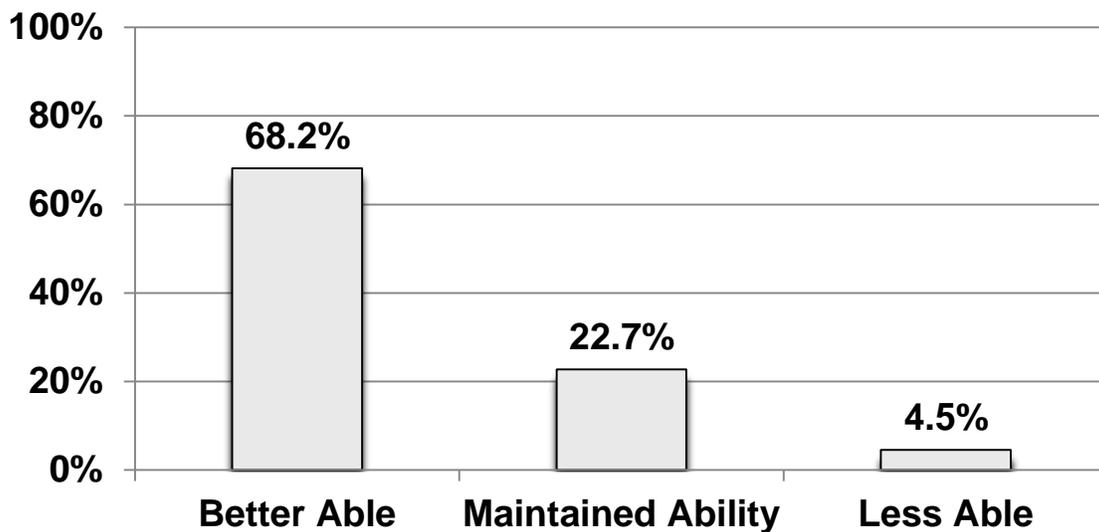
Functioning with Devices/Equipment



Participants were asked whether they had received devices or equipment (e.g., canes, insulin gauges, magnifiers, bump dots, adaptive cooking items, writing guides, large button telephones) to help them function more independently. Twenty-eight (84.8%) of the 33 respondents stated that they had received or purchased some device or equipment through the program. Two of the five respondents who had not received any devices/equipment indicated that they would have liked to have received this service as part of their program.

Regarding those participants who had received equipment, 22 (84.6%) of the 28 respondents stated that this service had improved their ability to function independently; four (14.2%) had maintained their ability to function independently; and three (10.7%) reported that they were not using any of the devices attained through the program. Examples of reasons why respondents were not using devices/equipment included “do not need it,” “need more training,” “haven’t received it yet,” and “doesn’t help much,” etc.

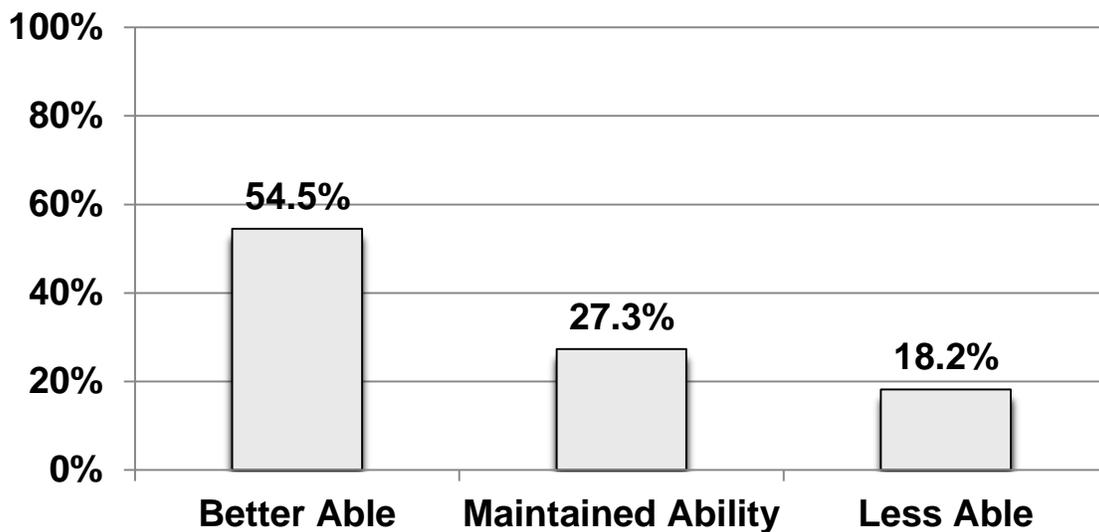
Communication Skills Functioning



Participants were asked whether they had received services to help them improve communication skills. Examples included training using magnifiers or other magnification devices; braille instruction; keyboarding or computer training; using the telephone; using handwriting guides; telling time; or using readers or audio equipment. Twenty-two (66.7%) of the 33 respondents stated that they had received these services. Six (54.5%) of the 11 respondents who had not received communication skills training indicated that they would have liked to have received these services as part of their program.

Regarding those participants who had received communication services, 15 (71.4%) of the 22 respondents reported that they were now able to function more independently; five respondents reported they had maintained their ability; and one respondent reported being less able to function independently due to lack of training; and one response was not reported.

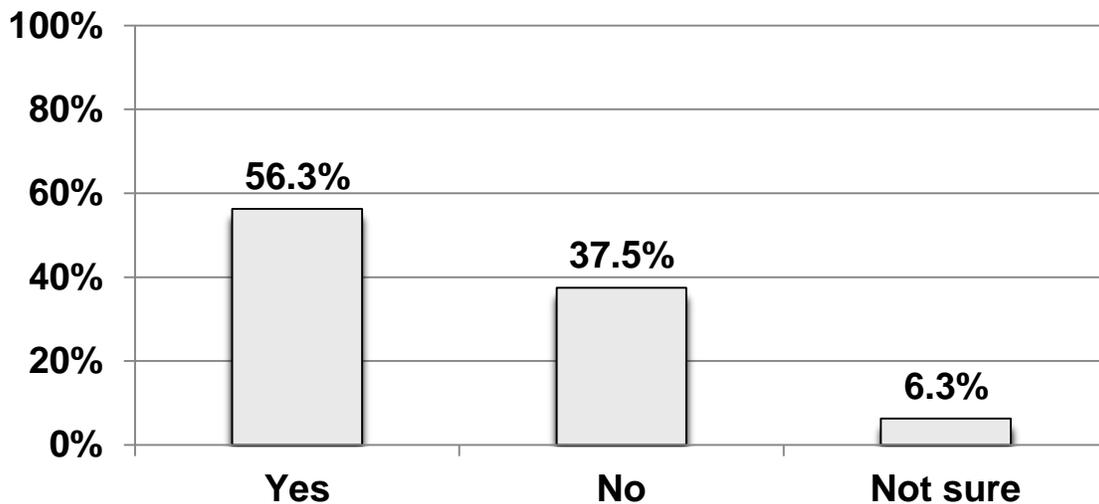
Daily Living Skills Functioning



Participants were asked whether they had received services to help them with their daily living activities, such as food preparation, grooming and dressing, household chores, medical management, or shopping. Eleven (33.3%) of the 33 respondents stated that they had received these services. Eight (36.4%) of the 22 respondents who had not received daily living skills training indicated that they would have liked to have received these services as part of their program.

Regarding those participants who had received daily living skills training, six (54.5%) of the 11 respondents stated that these services had made them better able to function independently in their home and/or community. Three (27.3%) of respondents reported that they had maintained their ability to function independently. Two (18.2%) individuals reported that they were less able to function independently after services due to lack of appropriate training.

Services Provided Helped Maintain Living Situation



Participants were asked whether services may have helped them to remain in their own home (as opposed to going into an assisted living facility, nursing home, or relative's home). Eighteen (56.3%) reported services helped them remain in their own home or community. Twelve (37.5%) individuals reported that services did not help with this, and two (6.3%) weren't sure if receiving services helped them maintain their living situation. One participant declined to respond to the question.

Survey Comments from Consumers

The telephone survey included an opportunity for respondents to provide additional comments following any question and at the end of the interview. These comments are included in Appendix C. Efforts were made to capture participant comments verbatim. Although consumers generally provided positive feedback regarding their IL services, some consumers indicated the need for additional assistive technology devices and services.

IV: On-Site Review

As part of the program evaluation, an annual on-site review is conducted to observe program activities. Examples of activities generally include meeting with administrative and direct service delivery staff, observing service delivery to consumers, and reviewing case folders. The FFY 2013 on-site review was conducted August 26-27, 2013. Dr. Jamie O'Mally (P.I.) and B.J. LeJeune began the site visit with an orientation meeting with staff from DSB and WSB. DSB staff included Katy Morris, Director; Christy Lamas, Director of Field Services; Mary Douglas, Older Blind Project Manager; and Lou Talley, former Older Blind Project Manager. Staff from WSB included Larry Dickerson, President and Executive Director; Tony Woodell, Chief Operating Officer; Jay Stitlely, Director of Rehabilitation Programs; Kristal Kinsey, Administrative Assistant; and contractor Dr. Janet Ford, who serves as the Older Blind Program Coordinator. Major topics discussed during the orientation meeting included the purpose of the review, project activities to be completed during the review and an overview of the DSB-STEP service delivery process including referral sources, eligibility, services provided, waiting lists, and staffing of the project.

Service Delivery. DSB provides the majority of referrals to WSB and prescreens them for eligibility. In response to recommendations from the January 2012 on-site review of the FFY 2011 contract, an order of selection has been implemented in determining the process for responding to the backlog of referrals. The criteria for DSB referrals are that the consumer has a vision loss of at least 20/50 with an imminent danger of institutionalization, with the understanding that those with the most critical need will be given priority. DSB referred 86 persons during the 2012-2013 fiscal year in compliance with the contract of services. In addition, both DSB and WSB receive referrals from community resources including a strong referral base from area medical eye care specialists and referrals from people who hear about the services from others who have vision loss, as well as community based social services programs. There are currently approximately 900 persons on a waiting list for services, and as it is possible, contact is made with these people to provide assistance. The list is dynamic and during the first few months of the project year, many were processed and referred to other resources in the community. This is a combined list from DSB and WSB, and is reviewed regularly at monthly meetings between the DSB Older Blind Project Manager and the WSB Older Blind Project

Coordinator. The administrative assistant triages these outside referrals to prioritize those eligible for the program.

Basic demographic data on each referral is collected, including date of birth, address, and referral source. This information is provided to Kristal Kinsey, administrative assistant, who constructs a working paper file and an electronic file using the ETO case management system. She functions as the primary intake worker and bears the responsibility to triage consumers. Ms. Kinsey then mails a letter to referred individuals letting them know when to expect a contact from program staff. If community-based services are appropriate, Dr. Ford conducts the initial assessment, consults with the consumer in developing an independent living plan, and provides rehabilitation teaching (RT) services (e.g., daily living activities, assistive technology, independent living skills, communication skills) in the community, as appropriate. If community-based orientation and mobility (O&M) services are recommended, services are provided by WSB staff. A center van is available to provide transportation for provision of services across the state. If center-based RT, low vision, or O&M services are recommended, the appropriate WSB teaching staff provides the services. Although she is only part-time, Dr. Ford oversees all DSP-STEP case and caseload management for the entire state. She sometimes utilizes the assistance of local WSB staff in the Little Rock area to cover services there, but she is responsible for direct service delivery for the rest of the state. She indicates that often consumers from more rural areas come to Little Rock from other parts of the state for their initial assessment and some training.

Observation of service delivery. Four consumers of the DSP-STEP program were scheduled for observation during the review: one consumer received an initial O&M assessment at WSB; three were closed but were receiving services in the community. One person canceled and so only two were seen in the community. We were told that we could not see consumers who were currently active in their rehabilitation program because of proprietary restrictions, and therefore we observed consumers who had completed their program, but were receiving additional services from WSB. The first consumer observed was in his 80's and had suffered a rather sudden vision loss from an unknown cause at the first of the year. He and his wife had been desperate for services. He received O&M, and some ADL skills, and could not say enough positive things about the program. When asked about future services, he wanted to participate

in the iPad training and was interested in training for the senior Olympics. He is very dependent upon his wife and she indicated that managing their finances is very challenging for her and a point of considerable friction between them.

The second home visit was to a woman who was congenitally blind and wanted to brush up on O&M between guide dogs. She lives with her husband who is still working but who is also visually impaired. She had participated in the Healthy Habits program and was very enthusiastic about the services she received. She also received an iPad and mentioned that she explored apps, assisted others with it, and provided articles for inclusion in the WSB blog.

The third consumer observed lost his vision due to Glaucoma and was very dependent upon his wife who died in June. After her death, he was placed in a "facility" in California and when funds ran out was sent to his brother's home in Arkansas. He has a learning disability and was confused concerning his health issues. He indicated his only health problem was his eyes, but his sister-in-law indicated that he was diabetic, and she and her husband managed his medications. He stays with her mother while they are at work, but they are not comfortable leaving him alone. He is a smoker with a family history of emphysema. His sister-in-law indicated that he stopped taking his glaucoma medicine years ago because it burned his eyes and subsequently lost his vision. He described that he could see some, but was not able to correctly answer any questions in a preliminary functional vision assessment. He walked with a support cane that he said he used to find obstacles in his way. He did well on his initial O&M assessment, but tired very quickly. He seemed rather reluctant to continue training. All three consumers observed were totally blind and lived with a family member. The first two seemed to be in very good physical and mental health, and the third consumer seemed to be more limited in his cognitive abilities.

Case file reviews. Several hardcopy case files were reviewed; two were cases of consumers who were observed receiving services during this site review. It was our understanding that the hardcopy files we reviewed were Dr. Ford's field folders and that comprehensive information was stored in the electronic case management system. The hardcopy files included the types of materials that someone would want in the field - but also included letters of acceptance, some eye reports, and miscellaneous case notes. Some files did not

include medical reports confirming presence of a visual impairment. Other files included individualized plans with only minimal detail regarding specific services to be provided. Further review of the electronic files of the two consumers we saw in the field was more complete, although assessment information and plans with measurable outcomes were missing. Dr. Ford showed us several versions of different assessments that had been done on one consumer and indicated she was in the process of transitioning her field assessment instrumentation and plan formats. The plan she was currently field testing was based on an IEP plan and had a place for indicating levels of mastery. However, the goals were very general areas such as O&M or ADL skills and we encouraged her to provide greater detail and consider more measurable goals.

Exit meeting. A brief summary of activities conducted during the review was reported to WSB and DSB administrative staff, including findings from observations of service delivery to individual consumers and from reviews of consumer files. It was noted that substantially more consumers had received IL services than required under the contract. The following suggestions for program improvement were also discussed during the exit meeting:

- Need to clarify order of selection and eligibility requirements between agencies. This issue may be clearer in the minds of those involved than we were able to understand during the visit. The two consumers we met who were recent graduates of the program did not appear to meet the “risk of institutionalization” requirement that we understood to be in place. There are likely other measures that are being utilized to prioritize need, but we were never able to get a clear sense of what they were. We were concerned that the responsibility for making those decisions beyond the ones referred by DSB appears to be that of Ms. Kinsey and are based on extensive telephone conversation, rather than an in-home assessment.
- Need to develop a plan to address the waiting list of 900 persons. The group brainstormed on this, concerning what might be done to communicate with people concerning their wait status. In the discussion, it appeared that almost half had been seen and processed during the first half of the year, but others appeared.

There was concern about manpower issues related to sending out letters to those on the waiting list, but it was noted that Ms. Kinsey spends between 10-15 hours per month in telephone calls with people in pre- or post-service statuses.

- Concern was expressed that Ms. Kinsey is overloaded with responsibilities and we suggested some ways to reduce her load. One major suggestion was rather than having Ms. Kinsey enter pre-test forms and post-test forms into the ETO database, these forms would be entered directly into the NRTC SurveyMonkey account by the instructors and service providers to alleviate duplication of effort. Dr. Ford indicated that it was not necessary to store the pre-form and post-form information in the ETO database. Currently, the pre-test and post-test are entered at the same time and instrument validity is compromised when the pre-test data is accessible when the post-test data is entered. An agreement was reached to change the data entry procedure so that all pre and post data is stored only with the NRTC, and direct service providers enter the data at the time of opening and closures. These changes reduce administrative workload, eliminate duplication of effort, increase instrument validity, and provide a more accurate picture of services received (e.g. date of form entry serves as a true indicator of time in the program). NRTC staff will send the pre-post data back to DSB and WSB at the conclusion of data collection.
- Continued need to develop partnerships with community organizations, including faith-based organizations, medical providers, and private businesses to reduce costs of blindness-related aids/devices, medical services, and accessible mainstream devices such as iPads and iPhones. Ms. Morris indicated that although they did considerable work to publicize an RFP for faith-based partnerships, they received no response.
- Need to establish and maintain a statewide network of peer-led peer support groups. Consumers (including pre/post service individuals) have occasional needs that could be met in a peer-support group setting.

Summary. Findings from the on-site review indicate satisfaction among consumers observed during the visit. Distribution and training on the use of iPads and slow cookers for the Healthy Habits were emphasized. In future site visits, we hope to be given the opportunity to observe low vision clients who are still receiving services. We would also like to observe a functional vision assessment with a low vision consumer to provide a broader experience of the work provided by WSB. WSB staff are in the process of revising field instrumentation and assessments. A major concern discussed during the on-site review is the tremendous backlog of referrals, for which recommendations are provided in the next section of this report. Caseload management concerns were also discussed during the on-site review. World Services' Older Blind Program Coordinator and DSB's Older Blind Project Manager continue to meet monthly to review program activities and to support ongoing program planning, implementation, and overall effectiveness of services provided to older blind consumers under the contractual agreement.

CONCLUSIONS AND RECOMMENDATIONS

FFY 2013 is the third year that DSB has entered into a performance-based purchase of services contract with WSB to provide IL services to individuals who meet eligibility requirements for the OIB Program. Project deliverables included:

- Provide outreach to 230 consumers, with the goal of serving a minimum of 86 individuals in the program.
- Conduct intake assessments; develop individualized training plans; provide training and assistive technology devices, as appropriate; and conduct exit assessments on 86 individuals.

In providing these services, the WSB program (DSB-STEP) employed 3.75 FTE staff—2.00 direct service and 1.75 FTE administrative staff. In addition to services provided by DSB-STEP, DSB in-house staff conducted multiple outreach activities to identify potentially unserved and/or underserved populations that could benefit from OIB services, charging .05 FTE administrative/support staff to the program.

Total FFY 2013 total expenditures/encumbrances for the DSB-STEP program were \$561,043, of which \$283,698 was from Title VII, Chapter 2 funding, \$195,612 from State funding, and \$81,733 from in-kind monies. This is a substantial increase from FFY 2012: \$306,164 total expenditures, of which \$193,300 was from Title VII, Chapter 2 federal funding, and \$38,620 from State funding. The OIB program had a substantial decrease in the number of consumers receiving services—172 served in FFY 2013 and 576 in FFY 2012.

DSB-STEP staff are the principal providers of direct services. An external consultant serves as the Program Coordinator in addition to providing direct services to consumers. WSB rehabilitation teachers, assistive technology instructors, and orientation and mobility instructors also provide services on a part-time basis. In addition to center-based services on the campus of WSB, the program uses a statewide itinerant model of service delivery to provide services to consumers in their homes and in their communities. Thus, individuals who might have difficulty with transportation, especially those who live in more rural areas, have opportunities to receive services.

Demographics and other characteristics (all consumers served). In FFY 2013 the percentage of consumers age 75 and older decreased slightly from 59% to 52%. Sixty-seven percent of individuals served were female. Almost three-fourths of consumers served were legally blind. Major causes of visual impairment included macular degeneration (48%), glaucoma (16%), diabetic retinopathy (10.5%), and cataracts (18.6%). The high incidence of multiple health conditions reported by consumers supports the continued critical need for IL services provided by OIB staff. Approximately 37% of consumers had musculoskeletal conditions, 36% had cancer, 36% had cardiovascular disease, 30% had diabetes, and 20% had hearing impairments. OIB services have the capacity to moderate the effects of these health conditions by providing individuals the skills and knowledge to improve health management and implement healthier life styles.

Approximately 76% of consumers served in the OIB program were White, 23% were African American, and one consumer was identified as being Hispanic/Latino (a decrease from five in FFY 2012). Estimates from the 2009 Census data (ACS, 2011) indicate that approximately 13% of individuals with visual impairments 65 and older in Arkansas are African American. The

percentage of participants served in the OIB program who are African American was approximately 23%. Due to the small sample size of Hispanics in Arkansas, we are unable to reliably estimate the number of individuals age 65 and older with visual impairments.

In determining if racial/ethnic minorities are equitably served in the OIB program, differences in prevalence of visual impairment among racial/ethnic groups and economic-related data should be considered. For example in Arkansas, estimated rates of visual impairment are higher for African Americans age 65 and older than for Whites age 65 and older (13.0% vs. 9.8%, see Table 2), but prevalence rates become higher for Whites at around 80 years and continue to increase at a higher rate with age (Prevent Blindness America, 2008). These higher rates are associated with a greater incidence of age-related macular degeneration among Whites. Thus among OIB consumers age 80+, we might expect to see a higher percentage of White consumers compared with other racial/ethnic groups to be served in the program. Conversely, preexisting socio-economic differences may result in a greater need for IL services among certain minority groups and therefore, higher numbers served.

Functional outcomes. The overarching goal of the OIB program is to sustain and enhance the ability of older individuals to remain independent in their homes and communities. Two sources of data provide information on how services have improved the IL functioning of consumers. First, pre- and post-functional data provided by DSB-STEP staff show the substantial impact the program has had on enhancing the independence of consumers closed during FFY 2013:

- 64% of consumers receiving assistive technology services are able to function more independently;
- 41% of consumers receiving O&M services are now better able to travel safely and independently in their homes and communities;
- 50% receiving communication skills training are now able to function more independently; and
- 45% receiving daily living skills training are able to function more independently.

In FFY 2012, at least 66% of consumers experienced gains in each of the functional outcomes listed above. Although the percentages of consumers in FFY 2013 experiencing gains are lower than those reported in FFY 2012, percentages who were able to *maintain* functioning on key IL actives were high. Overall in FFY 2013, approximately 97% of consumers had functional gains (43.3%) or were able to maintain functioning (54.1%), and only 2.6% experienced a loss in functioning.

In addition to data from pre- and post-assessments, MSU project staff conducted telephone interviews with a sample of closed consumers. Respondents provided feedback on their functioning after receiving assistive technology services, O&M services, and communication skills and daily living skills training. Approximately 63% of respondents reported overall gains on IL functioning. Further, 56% of respondents reported that they now had greater control and confidence in their ability to maintain their current living situations. These findings support the importance of, and the continued need for, OIB services.

Satisfaction with services. Consumers participating in telephone interviews were also asked to provide feedback regarding the manner in which they received services. Approximately 85% of consumers agreed or strongly agreed that services had been provided in a timely manner. Almost all consumers (96.8%) agreed or strongly agreed that their teachers/instructors were familiar with techniques and aids used by individuals who are blind or visually impaired. The large majority of consumers (90.6%) agreed or strongly agreed that they were satisfied with the quality of services they received. Respondents who had not received a specific service or who were dissatisfied with a specific service were encouraged to comment. Some consumers expressed concerns about length of time to receive equipment, needing more training on the iPad and computers, interest in receiving more orientation and mobility training, and desiring greater communication and resources from staff. All survey comments are provided in Appendix C.

Recommendations

- Develop a strategic plan to address backlogged referrals in a timely manner. Consider implementing a plan for overseeing the decisions made regarding eligibility for services to ensure that qualified staff adhere to systematic, priority-based screening criteria for incoming referrals.
- Continue joint monthly meetings between DSB and DSB-STEP administrative staff to review progress in serving the substantial number of potential OIB consumers now on the waiting list for services.
- Develop trained peer-led support groups to address the needs of pre- and post-service consumers. This will encourage empowerment among current and former clients, and will offer an opportunity for clients to receive support and resources at times when they do not meet high-priority eligibility for services. The performance-based contract with WSB does not include deliverables relating to support groups. Consider using DSB in-house rehabilitation teachers in providing continuing support to existing groups and in the creation of new groups, as appropriate.
- Consider developing financially-based eligibility criteria for the distribution of equipment. Given limited funding, equipment including iPads, slow cookers, and electronic magnification devices should be provided only as needed to clients requiring the equipment who would have difficulty purchasing it.
- Develop consistent procedures and instruments for assessing measurable goals. Increase the level of detail provided in field and electronic files for clients.
- Adhere to established procedures to improve the validity of data entry for pre- and post-functional assessments. Direct service providers should enter pre and post data at the time of intake and closure. All data should be submitted directly to the NRTC via the online web link. WSB should not maintain a copy of the data. At the request of DSB, NRTC will provide this file to both DSB and WSB once all data for the FFY has been submitted.

This will not only improve integrity of results, but will also reduce administrative workload.

- Consider reviewing the process for reporting expenditures by funding source in the 7-OB report. It appears there may be reporting inconsistencies that warrant further review. Specific examples of potential discrepancies are provided.
 - In FFY 2012, DSB reported in the 7-OB (Part I, line A3) that expenditures from the State (excluding in-kind) totaled \$38,620, and \$38,613 in FFY2011. In FFY 2013, State expenditures totaled \$195,612—an increase of more than 400% from the previous years.
 - In FFY2012, the total expenditures for administrative, support staff, and overhead were \$5,499. In comparison, this expense for FFY2013 was reported as only \$58.00.
 - The maximum accountability of WSB for services in FFY2013 was \$352,600; however, the total expenditures for direct services reported for FFY2013 were \$560,985. Given that the 7-OB report (Part II, section A1) indicates that no charges were made for direct service provided by the State agency (a difference of over \$177,000), it appears that these entries may warrant further review.

Summary. The DSB-OIB Program is commended for its work in providing statewide comprehensive IL services to older individuals with visual impairments. The majority of consumers receiving services are legally blind, age 75 or older and have additional health conditions. Overall, consumers report positive experiences and satisfaction with the services received. Further, evaluation data indicate that most consumers have been able to gain or sustain independence in key functioning abilities as a result of services. By increasing independent functioning through services, consumers enhance autonomy and quality of life, making them less reliant on community or family resources and support.

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APPENDIX A: Pre- and Post-Functional Assessments

Arkansas Older Blind Preform

Instructions: Please place appropriate information for each item in the corresponding box below that item.

Pre-Program Info

Required fields marked by *

1. * Consumer Case Number:

Please re-enter the Case Number:

2. * Consumer Last Name (initial)

3. * Consumer First and Middle Name (initials)

4. * Date of Birth (month/day/full year) (i.e., 03/24/1976)

5. * Age

6. * Caseworker Initials

7. Today's Date (month/day/full year) (i.e., 03/24/1976)

8. Source of Referral

9. Gender

10. Race and Ethnicity (multiple responses are permitted)

- a. White, not Hispanic/Latino
- b. Black or African American, not Hispanic/Latino
- c. American Indian or Alaska Native, not Hispanic/Latino
- d. Asian, not Hispanic/Latino
- e. Native Hawaiian or Other Pacific Islander, not Hispanic/Latino
- f. Hispanic or Latino of any race

11. Type of Living Arrangement

12. Type of Residence

13. Major Cause of Visual Impairment (as reported by the individual)

14. Non-Visual Impairments / Conditions at Time of Intake (as reported by the individual)

- a. Hearing Impairment
- b. Diabetes
- c. Cardiovascular Disease and Strokes
- d. Cancer
- e. Bone, Muscle, Skin, Joint, and Movement Disorders
- f. Alzheimer's Disease/Cognitive Impairment
- g. Depression/Mood Disorder
- h. Other

15. Is the consumer considered deaf-blind?

16. Does the consumer currently use any of the following?

- a. Braille
- b. Computer Access Technology
- c. Radio Reading Services and/or Newslines
- d. Library Services for the Blind
- e. Low Vision Aids, such as magnifiers, telescopes, CCTV/video magnifiers
- f. Daily Living Aids, such as clocks, insulin gauges, watches, calculators, kitchen equipment

17. Visual Impairment at Time of Intake

18. Onset of Significant Vision Loss (When loss began to affect performance of daily activities)

19. Highest Level of Education Completed

Performance Rating Scale

Instructions: The purpose of this rating scale is to determine a participant's ability to perform each of the tasks listed in the *Functional Capacities Assessment* Form. Pre-and Post-Test Program ratings will be compared to reflect changes in an individual's level of performance. Each participant should be assessed using the performance levels below. Whenever appropriate, demonstration of the task should be incorporated into the assessment.

Performance Level:

How well do you perform (specific task) ?

- Normal Capacity [no difficulty] - Consumer consistently performs task with satisfactory completion.
- Diminished Capacity[some difficulty]- Consumer performs task but satisfactory completion is somewhat affected by problems with speed, pain or confidence, and/or is only able to complete the task about 3/4 of the time.
- Reduced Capacity [serious/great difficulty]- Consumer performs task but satisfactory completion is seriously affected by problems with speed, pain or confidence, and/or is only able to satisfactorily complete task less than half the time.
- Incapacity - Consumer cannot perform task with satisfactory completion.
- Unable - Cannot obtain a reliable rating.
- N/A - Not a part of consumer's instructional program

Ratings should be based on the rehabilitation teacher's best professional judgment in collaboration with the consumer.

Functional Capacities Assessment

Instructions: Indicate the participant's current level of performance. Whenever possible, have the consumer demonstrate the skill.

General Health

1. Possess stamina to walk one block on a flat surface

2. Walks up and down steps

3. Hears and follows conversation (normal speech) in a room where others are talking

4. Can retain and repeat simple instructions or telephone numbers

5. Performs tasks like bending, stooping and reaching up

Kitchen Skills/Home Management

1. Pours liquid safely

2. Eats comfortably (using knife and fork, cutting, and moving food from plate to mouth)

3. Prepares a light meal

4. Uses stove/oven safely

5. Identifies food in a refrigerator or cupboard

6. Uses a microwave

7. Cleans home/apartment

8. Uses washer and dryer

9. Accomplishes light home maintenance tasks

Personal Management

1. Presents good personal hygiene

2. Uses shower or tub safely

3. Identifies and matches clothing

4. Cares for glasses, hearing aids, etc.

5. Accomplishes light mending/sewing, as needed

6. Uses telephone, as needed

7. Identifies and regulates medications

8. Accesses clocks and watches

9. Identifies and organizes money

10. Maintains financial records

Low Vision and Communication Tasks

1. Reads and writes handwritten notes

2. Reads or accesses regular size printed materials such as books and magazines

3. Reads or accesses large print materials

4. Operates television

5. Uses distance low vision aids

6. Uses near low vision aids

7. Signs name

8. Uses listening and/or recording devices

Orientation and Mobility

1. Travels safely in home or apartment

2. Travels safely in neighborhood

3. Travels safely using sighted guide technique

4. Travels safely in shopping areas

5. Uses public transportation

6. Negotiates steps safely

General Comments about the case:

Arkansas Older Blind Postform

Instructions: Please place appropriate information for each item in the corresponding box below that item.

Post-Program Info

Required fields marked by *

1. Consumer Case Number:

Please re-enter Case Number:

2. * Consumer Last Name (initial)

3. * Consumer First and Middle Name (initials)

4. * Date of Birth (month/day/full year) (i.e., 03/24/1976)

5. * Age

6. * Caseworker Initials

7. Today's Date (month/day/full year) (i.e., 03/24/1976)

8. Date of Initial Referral (month/day/full year) (i.e., 03/24/1976)

9. Client Status at closure

10. As a result of services, does the consumer currently use any of the following?

a. Braille

b. Computer Access Technology

- c. Radio Reading Services
- d. Library Services for the Blind
- e. Low Vision Aids, such as magnifiers, telescopes, CCTV/video magnifiers
- f. Daily Living Aids, such as clocks, insulin gauges, watches, calculators, kitchen equipment

11. Has there been a significant change in health or eye condition since the program began?

- a. Health
- b. Vision

Performance Rating Scale

Instructions: The purpose of this rating scale is to determine a participant's ability to perform each of the tasks listed in the *Functional Capacities Assessment* Form. Pre-and Post-Test Program ratings will be compared to reflect changes in an individual's level of performance. Each participant should be assessed using the performance levels below. Whenever appropriate, demonstration of the task should be incorporated into the assessment.

Performance Level:

How well do you perform (specific task) ?

- Normal Capacity [no difficulty] - Consumer consistently performs task with satisfactory completion.
- Diminished Capacity[some difficulty]- Consumer performs task but satisfactory completion is somewhat affected by problems with speed, pain or confidence, and/or is only able to complete the task about 3/4 of the time.
- Reduced Capacity [serious/great difficulty]- Consumer performs task but satisfactory completion is seriously affected by problems with speed, pain or confidence, and/or is only able to satisfactorily complete task less than half the time.
- Incapacity - Consumer cannot perform task with satisfactory completion.
- Unable - Cannot obtain a reliable rating.
- N/A - Not a part of consumer's instructional program

Ratings should be based on the rehabilitation teacher's best professional judgment in collaboration with the consumer.

Functional Capacities Assessment

Instructions: Indicate the participant's current level of performance. Whenever possible, have the consumer demonstrate the skill.

General Health-Related Areas

1. Possess stamina to walk one block on a flat surface
2. Walks up and down steps
3. Hears and follows conversation (normal speech) in a room where others are talking
4. Can retain and repeat simple instructions or telephone numbers
5. Performs tasks like bending, stooping and reaching up

Kitchen Skills/Home Management

1. Pours liquid safely
2. Eats comfortably (using knife and fork, cutting, and moving food from plate to mouth)
3. Prepares a light meal
4. Uses stove/oven safely
5. Identifies food in a refrigerator or cupboard
6. Uses a microwave
7. Cleans home/apartment
8. Uses washer and dryer
9. Accomplishes light home maintenance tasks

Personal Management

1. Presents good personal hygiene

2. Uses shower or tub safely

3. Identifies and matches clothing

4. Cares for glasses, hearing aids, etc.

5. Accomplishes light mending/sewing, as needed

6. Uses telephone, as needed

7. Identifies and regulates medications

8. Accesses clocks and watches

9. Identifies and organizes money

10. Maintains financial records

Low Vision and Communication Tasks

1. Reads and writes handwritten notes

2. Reads or accesses regular size printed materials such as books and magazines

3. Reads or accesses large print materials

4. Operates television

5. Uses distance low vision aids

6. Uses near low vision aids

7. Signs name

8. Uses listening and/or recording devices

Orientation and Mobility

1. Travels safely in home or apartment

2. Travels safely in neighborhood

3. Travels safely using sighted guide technique

4. Travels safely in shopping areas

5. Uses public transportation

6. Negotiates steps safely

General Comments about the case:

◀▶

▲■▼

APPENDIX B: Program Participant Survey

**Arkansas Division of Services for the Blind
FY 2013 Program Participant Survey**

Instructions: I am _____ from Mississippi State University. The Arkansas Division of Services for the Blind has asked us to contact you to ask about the services you received from World Services. You can help improve the program by providing your opinion of the services you received. Your participation in this research is completely voluntary, and you may skip any questions that you do not wish to answer. This should take only about 10 minutes to complete. Your answers are confidential, so we do not need your name. Your responses are greatly appreciated and any comments you might have will also be appreciated. I can address questions you have about the interview, or you can contact NRTC Blindness and Low Vision staff at 1800-675-7782.

*Can we complete the interview now?

We would first like to know more about the different services you may have received. I will ask if you received a particular service. If you received the service, I will then ask how the service may have helped you become more independent. In addition to answering the questions, if you have any comments, I would also like to hear those.
(Interviewer, if respondent answers negatively, please ask him/her to comment.)

Please respond to each statement with one of the following options:

Strongly Agree

Agree

Neither Agree Nor Disagree

Disagree

Strongly Disagree

Services were provided in a timely manner (services proceeded at a reasonable pace).

My teacher/instructor was familiar with techniques and aids used by blind and visually impaired individuals.

Please respond to the next statement with one of the following options:

Strongly Satisfied

Satisfied

Neutral

Dissatisfied

Strongly Dissatisfied

No Answer

How satisfied were you with the quality of services you received? (*Comments if not satisfied*).

Next, I would like to know more about the different services you may have received. First, I will ask if you received a particular service. If you received the service, I will then ask how the service may have helped you become more independent.

1. You may have received services to help you travel more safely and efficiently in your home and/or community." For example, you may have been provided training in how to use a cane or a sighted guide to move around. Did you receive this service? Yes No

1a. (*If did not receive service*) Is this a service you would have liked to have received?
 Yes No

1b. (*If received service*) After receiving travel services, would you say that you
 are now better able to travel safely and independently in your home and/or community.
 have maintained your ability to travel safely and independently in your home/community.
 are now less able to travel safely and independently (*ask respondent to comment*).

2. You may have received devices or equipment, such as canes, insulin gauges, magnifiers, bump dots, adaptive cooking items, writing guides, or large button telephones to help you function more independently. Did you receive any of these devices or equipment? Yes No

2a. (*If did not receive*) Were you interested in receiving any of these devices?
 Yes No

2b. (*If received*) Can you give me some examples of the things you received that may have helped you become more independent?

2c. Would you say that these devices and/or equipment have....
 improved your ability to function more independently?
 helped you maintain your ability to function more independently? OR
 I am not currently using any of these devices or equipment (*ask respondent to comment*).

3. You may have received training to help you improve your communication skills; for example, you may have received training in using magnifiers or other magnification devices; braille instruction; keyboarding or computer training; using the telephone; using handwriting guides; telling time; using readers or audio equipment. Did you receive instruction or training in any of these areas?
 Yes No

3a. (*If did not receive training*) Is this a service you would have liked to have received?
 Yes No

3b. (*If received training*) After receiving this, would you say that you
 are now able to function more independently?
 have maintained your ability to function more independently?
 are less able to function independently (*ask respondent to comment*)?

4. You may have received services that helped you with your daily living activities, such as food preparation, grooming and dressing, household chores, medical management, or shopping. Did you receive services that may have helped you in any of these areas?

Yes No

4a. (If did *not* receive services) Are these services you would have liked to have received?

Yes No

4b. (If received services) After receiving this service or services, would you say that you

are now able to function more independently?

have maintained your ability to function more independently?

are less able to function independently (*ask respondent to comment*)?

5. Compared with your functioning before services, would you say that

You now have greater control and confidence in your ability to maintain your current living situation.

There has been no change in your control and confidence in maintaining your current living situation.

You now have less control and confidence in your ability to maintain your current living situation. (*Ask consumer to comment*).

Now, I would like you to answer a few questions about yourself.

1. What is your age? _____

2. Are you Male Female ?

3. Do you _____? (*check only one*)

Live in a private residence (home or apartment)

Live in a senior living/retirement community

Live in an assisted living facility

Live in a nursing home/long-term care facility

Other (*Interviewer ask for clarification*)

4. What main type of eye problem do you have?

Macular Degeneration

Diabetic Retinopathy

Glaucoma

Cataracts

Retinitis Pigmentosa

Other (*interviewer please specify*) _____

5. Do you have a hearing loss? ___Yes ___No

5a. If yes, how would you rate its severity?

(1) Mild

(2) Moderate

(3) Severe

6. Do you have another impairment or health problem besides your vision or hearing problem?

___Yes ___No

(If individual answers yes, please list below.)

7. Has your overall health _____ over the past year?

___worsened

___improved

___remained about the same

8. Could you tell me your race or ethnic background. Are you...

___Hispanic/Latino of any race

(For individuals who are not Hispanic/Latino only, check below)

___American Indian or Alaska Native

___Asian

___Black or African American

___Native Hawaiian or Other Pacific Islander, including Marshallese

___White

___Two or more races

___Race & ethnicity unknown *(Interviewer, mark if consumer refuses to answer question)*

I have just two more questions for you.

9. In the last few months have you experienced any changes in your living situation; for example, have you moving from your normal residence to another residence such as a senior living or assisted living facility) that has resulted in your becoming less independent?

— Yes *(interviewer if yes, please ask for details)*

— No

— Not sure

9a. In your opinion, have the services provided by World Services helped you remain in your own home or community (as opposed to going into an Assisted Living Facility, nursing home, relative's home, etc.)?

Yes _____

No _____

Not sure _____

Are there any additional comments you would like to make?

APPENDIX C: Comments Survey Participants

AR 2013 Consumer Survey Comments

Manner in which services were provided:

1. Services were provided in a timely manner (your program preceded at a reasonable pace)?
 - I did not receive my Ruby quickly. It took a really long time.
2. Your teacher/instructor was familiar with techniques and aids used by blind and visually impaired individuals?
 - *No comments submitted.*
3. Were you satisfied with the quality of services?
 - I did receive an iPad and I was satisfied with that, but [STAFF] had not helped me to get the Ruby.

Services received:

You may have received services to help you travel more safely and efficiently in your home and/or community. For example, you may have been provided training in how to use a cane or a sighted guide to move around.

- 1a. *(If did not receive service)* Is this a service you would have liked to have received?
- 1b. *(If received service)* After receiving travel services, would say that you are now better able, have maintained your ability, or are now less able to travel safely and independently?
 - I did not get the chance to practice outside and I am terrible with outside and I get lost.
 - They've been very helpful about being here when I need them.
 - Not anymore, but then yes. I had a very good instructor.

You may have received or purchased devices or equipment such as canes, insulin gauges, magnifiers, bump dots, adaptive cooking items, writing guides, or large button telephones to help you function more independently.

2a. (If did not receive service) Were you interested in receiving any of these devices?

2c. (If received/purchased items) Would you say that these devices/equipment have improved or helped maintain your ability to function more independently, or are you not currently using any of these devices/equipment?

- iPad -- She said that it would help us stay in our homes longer, but I just can't figure that one out. (Laughs.) But I do use it everyday. It just hasn't helped to improve my independence.
- Cane and iPad and Mouse for computers
- I received a crockpot and some magnifiers and bump dots.
- Cane, magnifiers, Ruby.
- Magnifying device, the Ruby, CCTV
- CCTV
- Cane If I didn't have it I couldn't find anything at all.
- Cane
- Magnifier with light, mirror, monitor with mouse to make words larger, 20/20 pen and a big tablet. -- Her eyes have gotten so bad, that those devices don't seem to help much.
- A computer, windows screen reader, a cane, talking clocks, dictionary, calculator, and several other items.
- magnifying glasses and cane
- iPad and magnifiers and pens
- Canes, bump dots, adaptive cooking items, writing guides, and large button telephone.
- Cane -- I'm using the device more, but I need more training on it.
- Cane -- I have not received my cane yet.
- Magnifiers, glasses, and magnifier for tv.
- white cane, magnifier, cones, markers, catalogs,
- Intel reader, magnifier, recorder.
- Cane, signature guide, blood pressure glove, lined paper, pens, and an iPad.
- Cane, measuring cup, magnifiers,
- Cane.
- Cane -- I got it just in case I need it, but right now I do not feel like I need it.
- Ruby and reader
- Cane, pressure cooker, talking machine.
- In the mobility area, I received a pair of glasses (with sonar and vibration). I also received some software (DocuScanPlus) and a scanner that allowed me to read scanned images PDF files. Another piece of equipment I received was a shower

bench. I injured my foot and needed it to sit down for showers and they provided that-which was extremely helpful! -- They certainly made more independent! The scanner has allowed me to read items that I couldn't read before. I used to get extremely frustrated, but with this program, it's so much easier.

- Red Ball
- Ruby Reader and a cane
- Ruby magnifier -- It helps me to read things when I'm not at home. I have a CCTV at home.
- I received an iPad and a talking bathroom scale.

You may have received training to improve your communication skills; for example, you may have received training in using magnifiers or other magnification devices; braille instruction; keyboarding or computer training; using the telephone; using handwriting guides; telling time; using readers or audio equipment.

3a. *(If did not receive service)* Is this a service you would have liked to have received?

3b. *(If received service)* After receiving communication services, would say that you are now better able, have maintained your ability, or are now less able to function independently?

- I learned how to use those devices and I learned all about them, but the training hasn't helped me to become more independent because I have not received a Ruby or any of the other devices we went over. And my daughter taught me to use my iPad, not [STAFF].
- Some of my teachers were really good, but I wanted to learn a lot more about computers. I felt like I could have been better.
- She was taught how to use the lighted magnifier and the monitor, but because her eyes are getting worse, she is less able.
- I would like to see if they could help me use my computer again.
- The intel reader I learned to use helps so much!
- Still learning how to use the iPad.

You may have received services that helped with your daily living activities, such as food preparation, grooming and dressing, household chores, medical management, or shopping.

4a. *(If did not receive services)* Are these services you would have liked to have received?

4b. *(If received services)* After receiving service(s), would say that you are now better able, have maintained your ability, or are now less able to function independently?

- I learned about quick meals and other beneficial things.
- I didn't really receive enough training in the home for independence there. (About five weeks.)
- I need some more training though especially in eating my food, and cutting things like the meat.

5. Compared to functioning before services, would you say that you now have greater control and confidence, there has been no change in control and confidence, or you have less control and confidence in your ability to maintain your current living situation?

- Anything that he learned before after he came out of the hospital, he has forgotten. He's become weaker and acts lifeless.
- I never received any services although they came out here one time. I've had a lot more problems with my eyes and by knees since then.
- Especially with the magnifiers!
- It's built my confidence to the point that I feel like I can continue to function.
- They gave me information I needed, but my functioning level is still the same.
- I would say that it slightly helped.
- Just because my mom's eyes have gotten so much worse, and she's having more problems with every day living.
- I can use the microwave.
- Without the services I've gotten, I would have been totally dependent on others for everything. The cane has truly helped me.
- The reader has helped to keep me busy. Without it, I would be really bored.

Additional comments:

- I think that the services would help him, but he hasn't received any services. But as far as World Services, they were wonderful to work with, I just wish he could have gotten more help. He was staying at the over night there and was having anxiety, so I had to come pick him up. They just never contacted us about receiving services again.
- I thought that maybe [STAFF] may have taught us more about how to find insurance and what kind and type we might need. I went to school on rehab and I feel like our meetings should have been a more one-on-one case. Also, help with shopping is offered by others and not many people know that. I don't even think [STAFF] knows that. But there was just some things that went on that I wasn't sure about. Everyone needs help and you have to ask for help, but it seems like this help was just done kind of strangely. But the program is definitely a great thing, but it just needs improvement.
- [STAFF] has been great. But I wish I could read, but I can't because my eyes bother me and I can only do it for a short period time.
- I am very praiseworthy for the world services for the blind. And knowing that I always have help, keeps me confident.
- My counselor was wonderful, but he's passed away now.
- It's a great service and I hope that it can continue because it gives us great ideas to help better and maintain our independence.
- I did have vision until 23, and I went to World Services and there was a certain amount of help I received at that time. But I've been learning to work with computers and I want to know more. I'm not getting any kind of understanding of how to work with them or anything. I'd just like to be able to use my knowledge with stuff like that.
- We really like [STAFF]. She was always so helpful when we got to see her. But because she had such a heavy workload, it seemed like we didn't get to see her as much at times. (Daughter completed interview.)
- I got an iPad as well, but I'm not sure if it was through them.
- I really want to compliment [STAFF] because she has went out of her way to help us. I really want her to receive all the credit that she is due.
- I just think I need more training especially in mobility and home services.
- I'm moving from my normal residence to AR which will improve my independence. The only big problem I have was that I didn't have enough time on training for software like Jaws.
- I would like to take computer lessons and learn how to do that. No more cassettes because everything is on computers now. I'd like to go to college too.
- [STAFF] has made it so much fun when we get together. And it's been wonderful.

- This is one of the best things that's ever happened to me. Their help has just been wonderful.
- The services are great and I love being able to learn how to work on the iPad and to use it.
- Our teacher is very educational. She's a wonderful teacher and person to be around.
- (Interview comment: The change in living situation was staying in the hospital after his foot injury where he said he became less independent because he could not do things on his own.)
- The services have helped me with the reading part and that's the main thing. I really appreciate everything. I know that I can have help if I need it.
- I have searched for services quite a lot since my eyes started giving me trouble. World Services have helped me through it all and provided me with so much. I could finally feel hopeful!

Appendix D: Part VII Narrative 7-OB Report

Part VII: Narrative

A. Briefly describe the agency's method of implementation for the Title VII-Chapter 2 program (i.e. in-house, through sub-grantees/contractors, or a combination) incorporating outreach efforts to reach underserved and/or unserved populations. Please list all sub-grantees/contractors.

Arkansas is a rural state characterized by a small population, primarily spread out over a large geographic area, with a few pockets in which there is a concentration of older blind individuals.

The Division of Services for the Blind is engaged in a contractual agreement with World Services for the Blind (WSB) to provide Older Blind Services on a statewide basis. Under the contract, World Services provides intake, assessment, rehabilitation teaching, orientation/mobility instruction, low vision services, technology services and follow-up services. The contract was renewed in October 2013.

The Division of Services for the Blind through the contract with WSB continues to seek referrals from and provide services to individuals in un-served or underserved populations. This includes identifying those referral sources more likely to have initial contact with minority groups, including faith based organizations, Centers for Independent Living, local contacts, and community outreach organizations. In addition, DSB is continuing the process of replacing some of the current, and inactive, Older Blind Program Advisory Committee members with a larger number of representatives from our minority communities. DSB will continue this effort as these groups change and grow.

B. Briefly describe any activities designed to expand or improve services including collaborative activities or community awareness; and efforts to incorporate new methods and approaches developed by the program into the State Plan for Independent Living (SPIL) under Section 704.

AARP, AAA, SHIP, and WSB conducted 19 Community Awareness Activities to consumers and the public on nutrition and assistive technology. Additionally, WSB maintains a blog for consumer concerns, issues, and upcoming events. Rehabilitation Teachers are strongly encouraged to work collaboratively with Centers for Independent Living, physicians, hospitals, and other locally available resources to provide comprehensive services to consumers. In an effort to expand collaborative efforts, the following organizations meet on a quarterly basis with the OIB Advisory Committee: Mainstream, World Services for the Blind, Area Agency on Aging, Library for the Blind, American Council of the Blind, National Federation for the Blind, Division of Aging and Adult Services, University of Arkansas at Little Rock (UALR), AR Information Reading Services, and two representatives from the Public Sector.

The staff of the Division of Services for the Blind, (DSB), members of the DSB Board, members of the OIB Advisory Committee, and consumers participate in blindness awareness promotional efforts throughout the state. DSB White Cane Day was held on the WSB campus this year and was attended by individuals, professional, and civic organizations. DSB and WSB are working in conjunction with HKNC, TAPS, and the Librart f/t Blind. In addition, staff participate in blindness specific support and consumer groups, Association of Persons in Supported Employment (APSE), Association for Education and Rehabilitation for the Blind and Visually Impaired (AER), local Lions Clubs and disability awareness activities.

DSB has initiated media exposure for the public awareness of Blind and Vending Facility Programs. Faith-Based Bridge contracts continue to engage rural and under-served populations. While these focus on VR services and consumers primarily, the additional awareness and publicity carry over to all programs. Finally, the new OIB service contract with World Services for the Blind (WSB) continues to provide access to an array of local services for the ever-growing population of older blind consumers by taking advantage of the extensive network of civic and other support groups aligned with WSB, but operating from a community base.

C. Briefly summarize results from any of the most recent evaluations or satisfaction surveys conducted for your program and attach a copy of applicable reports.

Arkansas Division of Services for the Blind (DSB) contracts with The National Research and Training Center (NRTC) on Blindness and Low Vision at Mississippi State University to provide a program evaluation of its OIB program. As part of the evaluation, consumers closed from the program after receiving services are interviewed about their experiences with the program. DSB has a contractual agreement with World Services for the Blind to provide IL services to consumers eligible under the Title VII, Chapter 2 program. World Services provides names of closed consumers and the NRTC Project Director and another experienced telephone interviewer contacts consumers to complete surveys. The NRTC then prepares a program evaluation report that includes consumers' feedback regarding satisfaction with services and how services have impacted their ability to live independently. In addition, pre-and post-functional data on all consumers served, demographic and service data from the annual 7-OB report, and findings from an on-site review of the program are included in the final report. The following provides demographic and outcome data from telephone interviews with closed consumers conducted in federal fiscal year 2013.

Demographic and Survey Data from Interviews

Most respondents (72.7%) were less than 80 years old. Two-thirds (60.6%) were female. Almost all participants (97%) reported living in a private residence; with one respondent living in a senior living/retirement community. Causes of vision loss included macular degeneration (12.1%), glaucoma (12.1%), cataracts (6.3%), retinitis pigmentosa (6.3%), and multiple or other causes (62.5%). Consumer satisfaction levels among those participating in the survey were high. In responding to satisfaction questions regarding delivery of services, i.e., manner of service delivery, types of services provided, and perceived outcomes of services—almost all of the participants expressed satisfaction. Participants were most satisfied with the expertise of staff (96%); overall quality of services (90.6%), followed by timeliness of services (84.8%).

Consumers responded to questions about IL services related to their ability to travel safely and independently in their home and/or community, communication skills, daily living skills, their perceptions of control and confidence in maintaining their living situations, and how devices and equipment had impacted their ability to engage in life activities. For each of these questions, consumers were asked if they felt they experienced an improvement, no change, or a decrease in their level of functioning because of receiving services. If they did not receive/request a service, they indicated so on the respective question. Note that percentages may not total 100% due to rounding.

- Among consumers receiving devices or equipment, 84.6% indicated that devices had improved their ability to engage in customary life activities, 14.2% reported devices had helped them maintain their ability, and 10.7% reported that they were not using any of the devices or equipment provided by the program.
- When asked about their ability to travel in the home and community, 50% of consumers reported they were better able to travel in their home and/or community, 33.3% reported no change, 16.7% reported being less able, and 63.6% reported not receiving/requesting the service.
- When asked about training to improve communication skills, 68.2% reported that they were now able to function more independently, 22.7% reported they had maintained their ability to function more independently, 4.5% reported a decline, and 33.3% indicated that they did not receive/request communication services.
- When asked about their ability to perform daily living skills activities such as food preparation, grooming and dressing, medical management, shopping etc., 54.5% of consumers reported being better able to perform daily living skills, 27.3% reported no change, 18.2% reported a decline, and 66.7% reported not receiving/requesting the service.

- When asked about functioning before services, 66.7% indicated they now have greater control and confidence in their ability to maintain their current living situation, 21.2% reported no change, and 12.1% indicated feeling less control and confidence.
- When asked about changes in lifestyle, only one respondent indicated a recent change in his/her living situation.

A copy of the complete program evaluation report conducted by the NRTC will be available after its completion in early 2014.

D. Briefly describe the impact of the Title VII-Chapter 2 program, citing examples from individual cases (without identifying information) in which services contributed significantly to increasing independence and quality of life for the individual(s).

Contracted services have assisted 38 clients with O&M in new environments which included counseling for those leaving their homes. Assisted individuals from hospital to new living arrangements. Taught 14 people to prepare simple meals in slow cookers to remain independent. Issued 53 iPads and provided 18 hours technical training at the center. Provided braille training to 6 clients at the center. Provided training in the regional area to ensure all clients have access to training.

E. Finally, note any problematic areas or concerns related to implementing the Title VII-Chapter 2 program in your state.

The greatest problem is with funding, as it is with everyone, but acquisition and retention of qualified staff is also a growing concern because of the declining availability of academic programs nationwide.