

September 12, 2008

## **BLIND REHABILITATION OUTPATIENT SPECIALIST PROGRAM PROCEDURES**

- 1. REASON FOR ISSUE.** This Veterans Health Administration (VHA) Handbook provides procedures for all matters regarding the Blind Rehabilitation Outpatient Specialist (BROS) Program.
- 2. SUMMARY OF CONTENTS.** This Handbook describes the scope of the BROS Program and procedural guidelines for providing outpatient blind rehabilitation services in Department of Veterans Affairs (VA) medical facilities.
- 3. RELATED ISSUES.** VHA Directive 1174 (to be published).
- 4. RESPONSIBLE OFFICE.** The Office of Patient Care Services, the Chief Consultant, Rehabilitation Services (117) is responsible for the contents of this VHA Handbook. Questions may be referred to the Director, Blind Rehabilitation Service at 202-461-7355.
- 5. RESCISSIONS.** VHA Handbook 1174.1, dated February 16, 2000 is rescinded.
- 6. RECERTIFICATION.** This VHA Handbook is scheduled for re-certification on or before the last working day of September 2013.

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## BLIND REHABILITATION OUTPATIENT SPECIALIST PROGRAM PROCEDURES

### 1. PURPOSE

This Veterans Health Administration (VHA) Handbook describes the procedures for the provision of services by Blind Rehabilitation Outpatient Specialists.

### 2. BACKGROUND

a. In 1995, VHA established the first Blind Rehabilitation Outpatient Specialist (BROS) positions. BROS services were established to complement the blind rehabilitation training provided at the VHA Blind Rehabilitation Centers (BRC), and to provide blind rehabilitation outpatient services to veterans whose rehabilitation needs are best met in their local areas. In this role, the BROS independently conducts assessments and training at the veteran's local Department of Veterans Affairs (VA) facility or in the veteran's environment of choice.

b. Combat in Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) has resulted in new patterns of polytraumatic injuries and disability. Recognizing the specialized clinical care needs of these individuals, VA has established a Polytrauma System of Care composed of Polytrauma Rehabilitation Centers (PRC), Polytrauma Rehabilitation Network Sites (PNS), and Polytrauma Support Clinic Teams and Polytrauma Points of Contact at selected VA facilities. The BROS serves as a member of the interdisciplinary teams (IDT) at the PRCs and PNSs, contributing their blind rehabilitation expertise to the provision of comprehensive rehabilitation.

### 3. DEFINITIONS

a. **Blind Rehabilitation Center (BRC).** A BRC is a special inpatient organizational unit in a VA medical center which provides comprehensive and individualized rehabilitation programs for blind and visually impaired veterans and active duty service members. An IDT approach is used in a peer support environment. Team members focus their efforts on promoting health, developing skills of independence, and improving the blinded veteran's adjustment to sight loss with the ultimate goal of successfully reintegrating the individual into the family and community environment.

b. **Blind Rehabilitation Outpatient Specialist (BROS).** A BROS is a multi-skilled, experienced, college or university trained blind rehabilitation specialist with a Bachelor's or Master's Degree in Blind Rehabilitation. The BROS is a specialist with advanced technical knowledge and competencies at the journey level in at least two of the following disciplines: orientation and mobility, living skills (vision rehabilitation therapy, and visual skills (low-vision therapy). The BROS has been cross-trained to acquire broad-based knowledge in each of these disciplines, along with knowledge of manual skills and computer access training.

c. **Blind Rehabilitation Instructor.** This position title refers to the BRC staff that assess, plan, and instruct in one of the BRC disciplines. It designates an instructor with a Bachelor's, Master's or higher degree in one or more of the specialized areas of working with persons who are visually impaired; or a professional who possesses a Bachelor's, Master's, or higher Degree

in an allied health profession who has expertise in one or more of the specialized areas of working with persons who are visually impaired.

d. **Blind Rehabilitation Specialist.** This VA position title designates a Visual Impairment Services Team (VIST) Coordinator.

e. **Computer Access Training.** This instructional area teaches the use of specialized access equipment necessary for a visually impaired person to independently operate computers. This includes evaluating and training the student to use large print, synthetic speech, or Braille access devices in order to perform basic computer operations and maintenance.

f. **Continuum of Care.** Vision rehabilitation services range from basic outpatient low-vision care provided by licensed eye care practitioners or providers, to intermediate and advanced outpatient low-vision care involving a team of eye care specialists and rehabilitation professionals, to outpatient blind rehabilitation services, and to inpatient blind rehabilitation services. Patients are referred to the type program that best matches their functional needs.

g. **Cross-Training.** Cross training refers to professional training that extends beyond an instructor's formal training, and is intended to maximize the instructor's area of expertise by combining specific instruction from other closely-related disciplines. Cross-training is provided by instructors with verifiable competencies in the BRC Program disciplines of living skills, orientation and mobility, manual skills, visual skills, and computer access.

h. **Excess Disability.** Excess disability is characterized by problems and task performance difficulties related to vision loss that have a substantial impact on the person's functional independence or personal safety, and that are out of proportion to the degree of visual impairment as measured by visual acuities or visual fields. Veterans whose vision is better than legal blindness may have excess disability due to:

- (1) Sudden or traumatic visual disorder (especially related to military service);
- (2) Disabling co-morbidities (e.g., hearing impairment, mobility impairment, etc.);
- (3) Systemic diseases that cause fluctuating visual impairment;
- (4) Combined losses of other vision functions (e.g., contrast sensitivity, stereopsis, etc.);
- (5) Sudden changes in caregiver status; or
- (6) Other reasons.

i. **Instruction (Basic).** Introductory training addresses the skills used by visually-impaired individuals for the management of everyday life tasks. These may include, but are not limited to: pre-cane skills such as use of a human guide and independent protective techniques; self-care techniques such as eating skills and personal grooming; health management such as labeling medicines; activities of daily living (ADLs) such as telling time, dialing a telephone and identifying money; using talking books; and simple adaptive kitchen skills.

j. **Instruction (Advanced)**. Advanced instruction involves the sequencing of lessons that are designed to integrate and expand techniques taught during basic skill instruction in order to perform more complex tasks. Examples include, but are not limited to: business area travel such as crossing streets with traffic lights and using public transportation, and adaptive kitchen skills such as hot meal preparation.

k. **Legal Blindness (Statutory Blindness)**. Legal blindness exists when best corrected central visual acuity in the better-seeing eye is less than or equal to 20/200, or visual field dimension in the better-seeing eye is less than or equal to 20 degrees at the widest diameter, even if central visual acuity is better than 20/200.

l. **Licensed Eye Care Practitioner or Provider**. An optometrist or ophthalmologist is a licensed independent practitioner or provider who examines; diagnoses; treats; prescribes medications, as well as optical and non-optical low-vision devices, and manages eye diseases and vision conditions within his or her clinical privileges.

m. **Living Skills**. Living skills is the instructional area that focuses on communication skills and activities of daily living. These skills encompass a broad range of activities including:

(1) Personal grooming;

(2) Eating skills, food preparation, household management; and

(3) Communication skills such as Braille, keyboarding, handwriting, and reading with the use of electronic scanners.

n. **Low-Vision Clinical Examination**. A low-vision clinical examination is performed by a licensed eye care practitioner or provider that determines the veteran's level of visual impairment and current visual functioning. It provides the best possible optical refractive correction, and determines the patient's ability to benefit from adaptive vision training and prescription of optical low-vision devices, as well as non-optical or electronic devices. The low-vision clinical examination must be performed in accordance with nationally-published optometric or ophthalmologic clinical practice guidelines.

o. **Manual Skills**. Manual skills are the instructional area designed to enhance skills in sensory awareness with an emphasis on adaptive and safety techniques. Skill training focuses on organization, tactual awareness, spatial awareness, visual skills, memory sequencing, problem solving, and enhances confidence. Activities range from basic tasks using hand tools to advanced tasks using power tools and woodworking machinery.

p. **National Program Consultant**. National Program Consultants are professional field representatives of the Director of Blind Rehabilitation Service. The Consultant provides ongoing support and consultative services to the VA BRCs and Clinics, BROS and VISTs.

q. **Ocular Health Examination**

(1) This examination, conducted by a licensed eye care practitioner or provider, identifies the level of, and reasons for, a person's visual impairment. The examination includes:

(a) A refraction to establish best-corrected central visual acuities (not using a preferred retinal locus),

(b) A thorough assessment of the visual system and ocular health to establish the diagnosis primarily responsible for the impairment, and

(c) Assurance that all ocular and visual disorders are being appropriately managed.

(2) If there is a significant visual field loss, a Goldmann Perimeter, Humphry Field Analyzer, or equivalent device, is used to determine the extent of the field loss according to the Veterans Benefits Administration (VBA) Fast Letter 06-21 on Measurement of Visual Fields.

(3) The examination provides the licensed eye care practitioner/provider with information essential to conducting or directing additional assessments and management strategies in order to deliver optimal visual impairment rehabilitative services.

r. **Optical Low-Vision Devices.** Optical low-vision devices alter the image focus, size (magnification or minification), contrast, brightness, color, or directionality of an object through the use of lenses or other technology.

(1) Such devices include, but are not limited to: habitual prescriptive spectacles (with or without tint), specialty contact lenses, microscopic spectacles, hand-held magnifiers, stand magnifiers, telescopes (monocular or binocular), head borne lenses, minifiers, prisms, closed circuit televisions (CCTV), and electronic optical enhancement devices (EOEDs).

(2) These optical low-vision devices must be prescribed by an appropriately credentialed and privileged optometrist or ophthalmologist.

s. **Orientation and Mobility (O&M).** O&M is the instructional area that addresses the establishment and maintenance of orientation to the environment and safe, efficient, and confident movement in the environment. In O&M, veterans use all senses, available environmental information, and the use of protective techniques and devices.

t. **Preferred Practice Patterns.** Preferred guidelines for VIST coordinators and Blind Rehabilitation Specialists (including BROS) that specify procedures, clinical indications for performing the procedure, clinical processes, setting, equipment specifications, documentation aspects, and expected outcomes (see Blind Rehabilitation Service website:

<http://vaww1.va.gov/blindrehab>).

u. **Visual Impairment Centers To Optimize Remaining Sight (VICTORS).** VICTORS are examples of outpatient low-vision clinical programs, which provide short-term low-vision

rehabilitation for visually-impaired veterans. There are currently four VICTORS programs located in Lake City, FL; Chicago, IL; Westport, NY; and Kansas City, MO.

v. **Visual Impairment Services Outpatient Rehabilitation (VISOR)**. VISOR is an example of an outpatient hoptel blind rehabilitation clinic providing an abbreviated rehabilitation program. There are currently two VISOR programs which are located in Lebanon, PA, and West Haven, CT.

w. **Visual Impairment Services Team (VIST)**. VIST is comprised of health care and allied health care professionals charged with the responsibility of ensuring that blind veterans are identified, evaluated, and provided health and rehabilitation services to maximize adjustment to sight loss. Representatives may include, but are not limited to: social work, ophthalmology, optometry, prosthetics, primary care, vocational rehabilitation, library service, nursing, audiology, podiatry, nutrition, psychology, VBA, blind veterans' consumer organizations, blind consumers, and state or community agencies for persons who are blind.

x. **VIST Coordinator**. The VIST Coordinator serves as the case manager who has major responsibility for the coordination of services for visually-impaired veterans and their families, and is often the entry point into the continuum of care for visually-impaired veterans. Duties include arrangement of appropriate rehabilitation services and devices in order to enhance a visually impaired veteran's functioning level (e.g., referrals to the VA's Continuum of Care, as well as outsourced services in order to enhance the veteran's functioning level). Other duties include identifying new cases of blindness, providing professional counseling, meeting specific objectives established by the VIST, arranging VIST Reviews, and conducting educational programs relating to VIST and blindness.

y. **VIST Annual Report**. An annual narrative is completed by all VIST Coordinators and submitted to Blind Rehabilitation Service, VA Central Office, through local administrative channels. The report details program developments, program highlights, and program goals. A copy of the report is sent to the National Program Consultant responsible for the VIST designated area, and is due no later than October 31st of each year.

z. **VIST Review**

(1) In this review, the VIST Coordinator conducts an assessment of the veteran's history, current skills level, adjustment to blindness, and needs.

(2) The VIST review includes: a comprehensive physical examination and ocular health examination, an audiological or low-vision clinical examination, and a VIST assessment of patient history, current skill levels, adjustment to visual impairment, and needs.

(3) This review establishes a description of the veteran's functional capabilities and limitations. The VIST Coordinator develops a treatment plan, which includes recommendations for other needed exams, services, and follow-up. When the VIST Coordinator utilizes reports from evaluations accomplished during the preceding year, this is called a "Component Annual Review."

aa. **Visual Skills.** Visual skills training enables veterans to gain a better understanding of their eye problems, and teaches them how to effectively utilize their remaining vision through techniques that improve visual perceptual and visual motor function. Visual skills training includes assessment and intervention with special low-vision devices designed to meet the various needs of the person served. These needs may include, but are not limited to, reading, activities of daily living, orientation and mobility, and home repairs.

#### 4. SCOPE

##### a. **Mission**

(1) BROS outpatient services are designed to complement the inpatient blind rehabilitation services provided at the VHA BRCs and Clinics, and to provide blind rehabilitation care to veterans whose rehabilitation needs are best met in their local areas. The BROS conducts assessments and training at the veteran's local VA facility or in the veteran's environment of need. This program design supports an effective continuum of care by providing immediate and individualized rehabilitation in locations that are accessible, and in settings that are the most appropriate for the veteran.

(2) The BROS also serves as a member of IDT at PRCs and PNSs; contribute their blind rehabilitation expertise to the provision of comprehensive rehabilitation services for individuals with complex physical, cognitive, and mental health sequelae of severe and disabling trauma.

##### b. **Services.** Services for all BROS include:

(1) **Assessments.** The BROS conducts assessments of patients in one or more of the key skill areas of blind rehabilitation. The basis of all intervention is to enhance function and help to develop compensatory strategies to deal with sight loss.

(2) **Interdisciplinary Treatment Planning.** Patients' individualized treatment plans are developed based on the identified needs and stated goals of the veterans.

(3) **Training.** The specific training provided to individual patients varies, depending on the veteran's needs and abilities. Such training may be provided at local medical centers, in client's homes or local communities, and in other environments where the veteran is likely to travel or perform ADLS. Instruction may be short or moderately long-term, although those individuals with extensive needs are encouraged to utilize the comprehensive rehabilitation services available at a VHA Blind Rehabilitation Center or other appropriate outpatient program within the Continuum of Care.

(4) **Prosthetic Recommendation.** Based on assessment of veteran needs, BROS recommends issuance of prosthetic aids and appliances related to vision loss within their scope of practice in accordance with VHA policy.

(5) **Consultative Services.** The BROS provides consultative services in response to requests for information on vision loss and blindness.

(6) **Veteran and Family Counseling and Education.** The BROS provides veterans and their families with education and assistance in understanding and adjusting to the effects of vision loss.

(7) **Staff Education and Community Outreach.** As a subject matter expert in the field of blindness, the BROS provides education and training in the dynamics of blindness, low-vision and VA blind rehabilitation services.

c. **Outpatient Model of Care**

(1) In the BROS model, blind and visually impaired veterans receive blind rehabilitation services through local assessment and training to:

- (a) Meet the immediate needs of veterans that impact safety,
- (b) Prepare for or complete an inpatient Blind Rehabilitation Center or Clinic program, or
- (c) Provide blind rehabilitation to veterans whose training needs are best met in their local areas.

(2) Each BROS has a defined geographic service area. In most cases, the primary service area corresponds to the service area for the VA facility where the BROS is located. However, BROS programs may serve one or more VA facilities, as resources and needs indicate.

*NOTE: BROS serving at the Network Polytrauma Sites may have additional duties related to Polytrauma that include areas larger than their normal geographic boundaries.*

(3) Coordination of care. Facilities shall coordinate the provision of blind rehabilitation services for veterans with services for the care of the visually impaired offered by State and local agencies, especially to the extent to which such State and local agencies can provide necessary services to blind veterans in settings located closer to the residences of such veterans at similar quality and cost to the veteran (from Public Law 109-461).

d. **Polytrauma Rehabilitation Model Of Care**

(1) BROS are involved in the provision of services at all points within the Polytrauma System of Care. This includes Military Treatment Facilities, PRCs, PNSs, and in the individual's home area.

(2) Interdisciplinary patient care. The BROS is a member of the interdisciplinary treatment team. This team, characterized by a variety of disciplines working together, conducts assessment, planning, and implementation of the patient's care plan. Continuous communication, collaboration, and coordination are critical to avoid fragmented care. The team functions as a unit, cooperating among disciplines to achieve maximum patient and family outcomes.

(3) Interdisciplinary Assessments. Each patient receives a full interdisciplinary assessment which is used to prepare individualized care plans for the patients. BROS assessments will relate to their areas of expertise.

(4) Interdisciplinary Treatment Plans. Each patient must have a coordinated and integrated interdisciplinary plan of care that includes all required disciplines and reflects the goals of the patient and family. The treatment plan addresses the veteran's goals and is individualized to meet the veteran's needs relevant to lifestyle, age, level of capability, and future plans.

(5) Interdisciplinary Care Delivery. Treatment team members continually evaluate performance results during the veteran's rehabilitation program, as they relate to expected outcomes, in order to determine the appropriateness of the treatment being provided. Any revisions to the treatment plan are made with the veteran's involvement. Revisions are based on demonstrated strengths, changing needs, and expected outcomes in order to ensure that goals are achievable and meaningful to the person receiving services. Team meetings are held when needed to monitor progress and update the care plan to reflect progress and new patient goals.

## **5. ELIGIBILITY FOR BROS SERVICES**

a. Blind Rehabilitation Service is committed to serving all eligible veterans and active duty personnel who need and can benefit from its unique services. Legal blindness based on measurement of visual acuity and visual fields have long been recognized as indicators of disability, and continue to be a primary test of eligibility for VHA blind rehabilitation services. Eligibility criteria for blind rehabilitation services must also address functional deficits and the rehabilitation needs of the person because of the complex relationship between visual function and the overall functional capacity of the individual.

b. In order for a person to be eligible for BROS services, the person must be enrolled in VA health care and meet one of the following criteria:

(1) Best corrected central visual acuity in the better-seeing eye less than or equal to 20/200, or visual field dimension in the better-seeing eye less than or equal to 20 degrees at the widest diameter, even if central visual acuity is better than 20/200.

(2) Blind rehabilitation services are needed for appropriate restoration of the individual's safety, functional independence, or for facilitating their personal or social adjustment to vision loss. This need may be based on the visual impairment alone or in combination with excess disability factors

## **6. PRIORITY OF CARE**

a. Priority of care will be provided to active duty military personnel, service-connected veterans rated 50 percent or greater for any combination of disabilities, and veterans who are service-connected for their visual impairment.

b. The priority for care also considers urgent need factors, such as:

- (1) Safety issues,
- (2) Medical issues,
- (3) Lack of a caregiver,
- (4) Vocational needs (e.g., attending school, employed),
- (5) No previous history of blind/vision rehabilitation services.

## 7. BROS AUTHORIZED SERVICES

### a. Assessments

(1) A BROS must conduct assessments of all clients. Assessments serve as the basis for all interventions designed to enhance function and develop compensatory strategies to deal with sight loss. These assessments address vision loss and safety needs that require immediate intervention.

(2) A BROS must conduct blind or vision rehabilitation assessments with veterans identified by VIST as needing a BROS program prior to being admitted to a BRC. The assessments includes evaluations in orientation and mobility, living skills, manual skills, visual skills, and (when indicated) computer access. The assessment format is mutually developed by the BROS and the BRC of jurisdiction, based on nationally designed blind rehabilitation standards. During the evaluation, the BROS assesses each veteran's abilities and needs for blind rehabilitation training, and addresses the veterans goals and readiness for any recommended training.

(3) A BROS must ensure that veterans with visual impairment who have vision receive a low-vision clinical examination by a licensed and privileged eye care practitioner or provider. The BROS will work with the optometrist or ophthalmologist to develop a visual rehabilitation treatment plan utilizing optical low-vision devices that were prescribed by an appropriately credentialed and privileged licensed eye care practitioner or provider and well as useful non-optical devices that enhance the use of vision.

b. Treatment Planning. Based on assessment results and in collaboration with the patient, BROS are required to develop a treatment plan addressing the veteran's specific needs and goals related to blindness and visual impairment. The treatment plan considers all available options for evaluation, training (VA and non-VA), issuance of prosthetics in accordance with VHA policies, and the setting which best meets the veteran's needs. The treatment plan is documented in the medical record, and is communicated to the VIST Coordinators and other services, as appropriate.

c. Instruction and Training. The BROS is authorized to provide blind rehabilitation training in the following blind rehabilitation skill areas: living skills, manual skills, orientation and mobility, visual skills, and computer access. The training program includes instruction in the use of assistive devices and equipment.

d. **Veteran and Family Education and Counseling.** The BROS provides education and counseling to veterans and their family members in order to facilitate maximum adjustment to vision loss.

e. **Use of VA and Non VA Services.** The BROS collaborates with the local VIST Coordinator to ensure that eligible blinded veterans are aware of services and benefits available to them through and outside VA. Where appropriate, a BROS will assist in the veteran's application for such services.

f. **Referral to Appropriate VA Healthcare Services.** The BROS works with veterans' health care providers to support the health care needs of veterans served by the BROS program. Referrals of a routine nature may be made through the VIST Coordinator as Case Manager.

g. **Prosthetic Recommendation.** The BROS is authorized to determine veterans' needs for prosthetic equipment related to vision loss. The BROS recommends issuance of prosthetics in accordance with relevant VHA Directives, VHA Handbooks, VHA Prosthetic Clinical Management Program (PCMP) Clinical Practice Recommendations policies, and existing national contract prosthetic guidelines on Aids for the Blind.

h. **Project Participation.** The BROS will participate in projects in support of the VHA Blind Rehabilitation Service program office.

## 8. SUPPORTIVE SERVICES

a. **VA Medical Centers.** The BROS and VIST Coordinators are key links between the VA facility, visually impaired veterans and their families, and the community. These links may serve as a powerful connection for visually impaired veterans in accessing the benefits and services provided by state and community blindness agencies, consumer groups, and veterans' service organizations. BROS should be involved in the review and updating of facilities Guide Dog policies and provisions.

b. **Ophthalmology or Optometry Service.** Ophthalmology Service or Optometry Service provide ocular health examinations, low-vision clinical examinations, treatment and management of ocular diseases and vision disorders as appropriate, and determination of visual function. Ophthalmologists and Optometrists must prescribe all optical low-vision devices and may provide basic instruction in their use. The BROS and eye care staff work cooperatively to ensure that veterans receive appropriate vision rehabilitation services.

c. **Prosthetic and Sensory Aid Service (PSAS).** PSAS provides prosthetic equipment and services appropriate to the needs of visually impaired clients, and maintains sufficient stock to ensure prompt availability.

d. **VIST Coordinator.** The VIST Coordinator is responsible for:

(1) Identification and screening of blinded veterans, and assisting as necessary with enrollment in VA healthcare.

(2) Making the eligible veterans aware of services and benefits available to them through VA and Non-VA sources, and where appropriate, assisting veterans to apply for such services.

(3) Assisting eligible veterans to apply for blind and low-vision rehabilitation training programs.

(4) Recommending prosthetic equipment for blinded veterans who may or may not be participating in the BROS or BRC Programs in accordance with VHA Handbooks, VHA Directives, and VHA PCMP Clinical Practice Recommendations policies.

(5) Coordinating non-BROS program training activities of veterans currently active in the BROS Program.

(6) Serving as liaison with local non-VA agencies, together with the BROS, to assist in the identification and/or provision of services to blinded veterans. The VIST coordinator has primary responsibility for making referrals and monitoring the progress of services provided by these agencies with assistance from the BROS and licensed eye care practitioners/providers to develop and help maintain relationships with local non-VA agencies.

(7) Coordinating the activities of the VIST.

e. **Inpatient Blind Rehabilitation Centers.** The inpatient BRC is responsible for:

(1) Coordinating the admission date, treatment planning, and post-discharge care with the BROS in a timely manner for veterans according to VHA policy.

(2) Providing interdisciplinary assessment and evaluation, planning, and intensive blind rehabilitation for veterans and active duty personnel.

(3) Providing training for the BROS.

f. **Outpatient Blind Rehabilitation Clinics.** An intermediate low-vision clinic, advanced low-vision clinic or outpatient blind rehabilitation clinic is responsible for:

(1) Providing low-vision clinical examinations by an appropriately credentialed and privileged optometrist or ophthalmologist in accordance with nationally published optometric or ophthalmologic clinical practice guidelines, performing functional assessments of daily living abilities, vision rehabilitation planning, prescription of low-vision and other prosthetic devices according to VHA policies, and vision and blind rehabilitation training for veterans and active duty personnel.

(2) Coordinating the rehabilitation care with BROS to ensure follow-up and outcomes assessment for veterans post-discharge.

(3) Providing training for BROS.

g. **VHA National Program Consultant.** The National Program Consultant is responsible for:

(1) Assisting in the initial orientation and training of new BROS through direct training and establishment of mentoring programs;

(2) Assisting BROS in developing personal development plans that address personal mastery, technical skills, customer services, and other aspects of the VA's High Performance Development Model;

(3) Assisting BROS in quality improvement efforts.

## 9. PROSTHETIC EQUIPMENT AND SENSORY AIDS

a. **Issuance.** Prosthetic issuance is in accordance with:

(1) VHA Handbook 1173.5, Aids for the Blind.

(2) VHA Handbook 1173.2, Furnishing Prosthetic Appliances and Services.

(3) VHA Handbook 1173.12, Prescription Optics and Low-Vision Devices.

(4) VHA policies on Prescribing Hearing Aids and Eyeglasses.

(5) VHA Prosthetics Clinical Management Program (PCMP) Clinical Practice Recommendations policies pertaining to issuance, prescription and provision of prosthetics.

(a) VHA PCMP Clinical Practice Recommendations on Prescription and Provision of Optical Low-Vision Devices to Aid in Overcoming Visual Impairment.

(b) VHA PCMP Clinical Practice Recommendations for Prescription of Closed Circuit Televisions (CCTVs) and Other Electronic Optical Enhancement Devices (EOED).

(c) VHA PCMP Clinical Practice Recommendations for Prescription and Provision of Daily Living and Mobility Devices for Legally Blind and Visually-Impaired Veterans.

(d) VHA PCMP Clinical Practice Recommendations for Audible Prescription Reading Devices.

(e) Other policies listed on the Prosthetics and Clinical Logistics Office website at: <http://vaww.pclo.med.va.gov>

(6) Existing national contract guidelines on Aids for the Blind.

b. **Criteria for Issuance.** Candidates must demonstrate the ability to utilize the equipment for the identified needs. Required documentation includes identification of need, training provided, and the capability of the veteran to utilize the equipment.

c. **Recommending Authority**

(1) The BROS may provide initial issuance of all non-optical and blind aids, provided the veteran has completed the required training and demonstrated the ability to properly use the requested equipment. The initial issuance of optical low-vision devices by the BROS requires prescription or concurrence from a licensed eye care practitioner/provider.

(2) Requests for prosthetics by non-VA service providers as part of community-based programs of instruction should be addressed by, or referred to the VIST Coordinator as case manager for the veteran.

(3) The BROS may provide replacement equipment and equipment upgrades for veterans who have participated, but are not currently participating, in a VA blind rehabilitation program. Where such upgrades require extensive re-training (e.g., new computer technology), the BROS will inform the VIST Coordinator who will coordinate a referral to the appropriate source, and monitor the progress of such instruction.

d. **Pre-BRC Issued Equipment.** When prosthetic equipment is issued prior to a veteran's admission to a BRC program, the BROS will encourage the veteran to bring the equipment to the BRC as appropriate. This enables the veteran to continue to use the equipment he has found useful, receive instruction or review in the use of the device if needed, or make any necessary adaptations to the veteran's equipment.

## 10. REFERRAL PROCEDURES

a. **Non BRC Referral.** The process for referral is as follows:

(1) **Identification.** The VIST Coordinator identifies the blinded veteran and coordinates services that include an ocular health examination, medical evaluation, psychosocial interview and patient education.

(2) **VIST Responsibilities.** The VIST Coordinator completes a VIST assessment, which describes the veteran's functional capabilities and limitations and includes a patient history, adjustment to blindness issues, and veteran's goals.

(3) **BROS Program Open Cases or Priority of Care.** The BROS opens a case after a referral has been received from the VIST Coordinator. The BROS program will be provided according to the priorities previously described in this handbook.

(4) **BROS Program Assessment.** The BROS conducts individualized assessments that may include: visual skills, orientation and mobility, living skills, manual skills and limited computer access training (as necessary), and documents the veteran's capabilities and needs.

(5) **BROS Program Individualized Treatment Plan.** The BROS, with input and concurrence from the veteran, develops an individualized treatment plan. The treatment plan includes: assessment results, veteran or family treatment program goals, objectives and recommendations for intervention. The treatment plan is documented in the veteran's record and the Blind Rehabilitation database. The BROS refers the patient to the VIST Coordinator documenting the need for referral to VHA low-vision services, local resources, including recommendations for particular instructors if available and appropriate. The VIST Coordinator is then responsible for making all necessary arrangements, and for monitoring the progress of the local services provided.

(6) **Rehabilitation Training.** The BROS provides training in their areas of expertise. The VIST Coordinator refers to qualified agencies as appropriate. When referring to non-VA agencies, the VIST Coordinator monitors the treatment process and keeps the BROS informed of any developments including the need to participate in revisions of the original referral objectives.

(7) **BROS Program Completed Services.** A veteran's case is closed with the BROS once goals and objectives are achieved, the patient's progress plateaus, the patient declines further service, or the patient is unable to participate in further service. If the veteran is referred for training in another element of the Continuum of Care or to a non-VA agency and follow-up services by a BROS are anticipated, the case will be closed after completion of the BROS follow-up treatment. When the case is closed, the BROS will enter a final summary in the veteran's medical record and inform the VIST Coordinator of the case closure. The VIST Coordinator will monitor the veteran's progress and make a referral to the BROS as indicated.

b. **BRC Referral.** The BRC referral process for outpatients is as follows:

(1) **Identification.** The VIST Coordinator identifies the blinded veteran and schedules a VIST Review. The VIST Review provides an evaluation that includes an ocular health examination, medical evaluation, hearing exam, initial benefit review, psychosocial interview, and patient education.

(2) **BRC Referral Procedure.** BRC referral procedures are completed by the VIST Coordinator. If there is an expectation of a BROS involvement, a referral is forwarded to the BROS.

(3) **BRC Referral Review.** The BRC Program reviews the referral and supporting documentation and decides within 20 working days whether to accept or deny for admission.

(4) **BRC Admissions Waiting List Referrals.** Applications received are automatically placed on the BRC Waiting List and placed in the "pending" status until the BRC Chief, or designee, starts the review process of the application. Referrals in the "pending", "review" and "accept" status are on the waiting list. Referrals requiring additional information are placed in the "in review" status while awaiting receipt of the requested information. The VIST Coordinator responsible for providing the additional information must respond with a plan of action within 10 working days and ensure the requested information is received by the BRC within 30 days, or provide justification for the delay in providing the necessary information

(note: up to 90 days is permitted for patient issues related to Audiology). The status of any referral can be viewed in the Blind Rehabilitation National Database.

(5) **BROS Opens Cases.** The BROS opens a case after a written referral has been received from the VIST Coordinator requesting pre-admission services.

(6) **BROS' Assessments.** The BROS conducts an individualized assessment, including evaluations in Visual Skills, Orientation and Mobility, Living Skills, Manual Skills, and (when indicated) Computer Access in order to:

- (a) Identify goals and determine needs,
- (b) Evaluate the veteran's ability to learn and retain information, and
- (c) Determine the veteran's readiness for inpatient training.

(7) **BROS' Individualized Treatment Plans.** The BROS, with input and concurrence from the veteran, develops an individualized treatment plan. The treatment plan includes assessment results, veteran or family training program goals, objectives and recommendations for intervention. The treatment plan is documented in the veteran's record.

(8) **Pre-BRC Training.** The BROS conducts pre-BRC training to address a veteran's urgent needs and documents services provided, informing the BRC that such training has been initiated so that the BRC is informed of the ongoing involvement of the BROS.

(9) **Admission to BRC.** In those cases where a BROS has been providing local training, the BRC will coordinate admission with the BROS.

(10) **BRC Program.** The BRC creates an individualized training program that addresses the veteran's needs, making reference to the BROS's program progress notes and recommendations and its own assessment processes. When possible and appropriate, the BROS will participate in veteran's staffing and discharge planning.

(11) **Post-BRC Training and Follow-up.** Following BRC services, and with consideration of final summaries and recommendations of the BRC staff, the BROS may provide additional services in the veteran's home and local community to meet the veteran's individual rehabilitation needs.

(12) **BROS' Completed Services.** A veteran's case is closed with the BROS once the veteran's goals and objectives have been achieved, the patient's progress plateaus, the patient declines further service, or the patient is unable to participate in further service. A final summary is documented in the veteran's medical records and the VIST Coordinator is informed. The veteran will continue to be followed by the VIST.

## 11. WORK ENVIRONMENT, EQUIPMENT, AND SUPPLIES

a. **Work Environment, Safety, Equipment and Supplies.** The work environment for a BROS encompasses a wide range of areas including, but not limited to:

- (1) VA facilities,
- (2) Veteran's home and immediate neighborhood,
- (3) Employment sites,
- (4) School campuses,
- (5) Residential areas,
- (6) Rural areas, and,
- (7) Downtown and urban areas.

b. **Office Space.** Each BROS program needs adequate office and clinical space to conduct assessments, demonstrate adaptive equipment (e.g., closed-circuit televisions and adapted computer systems), and provide training in multiple skill specialty areas to blinded veterans. The assigned space should be a minimum of 650 square feet, located in an area that is accessible and convenient to the blinded veterans.

c. **Government Vehicle.** BROS assessment and training must be conducted in areas that are specific to the individual needs of veterans. This requires frequent travel by government vehicle and public transportation wherever that may be available to veterans, often over a wide geographic area. Immediate access to vehicles is important to ensure an efficient assessment process. Each BROS is assigned a government vehicle for sole use to support efficient patient care. Public transportation rail/bus passes may also be required.

d. **Budget.** BROS programs are provided with start-up and ongoing operational funding to purchase training equipment, office equipment, and supplies. During outpatient training, the BROS may temporarily loan equipment as part of the evaluation and training process. The BROS program is expected to have sufficient funds available for the purchase and maintenance of a limited selection of loaner items.

## 12. DOCUMENTATION AND WORKLOAD REPORTING

a. The documentation of patient assessments, treatment plans, and progress notes must be consistent with VA requirements, as well as the requirements of The Joint Commission (TJC).

b. Workload data (i.e., encounter codes and Decision Support System information) are entered according to local medical facility policy. The stop code "217" is used to capture BROS program workload. Additional activities not captured by this stop code are noted in the VIST Program Annual Report.

c. The BROS records clinic activity in the BRS national database and in the electronic medical record. This includes: assessment, referrals, training, discharge summary and other patient encounter information.

d. The BROS will cooperate and participate in projects related to the Blind Rehabilitation Service, as directed by VA Central Office.

### **13. PROFESSIONAL TRAINING**

a. VHA Blind Rehabilitation Service provides professional continuing education and training programs for BROS.

b. New BROS must participate in training to enhance their skills and develop a cooperative working relationship with all other BRS field elements. The cross-training curriculum must include:

(1) Training in policies and procedures related to BRC services provided by the National Program Consultants, and at the regional BRC Program that serves the VA facility where the BROS program is located.

(2) Instruction in assessment and patient training in blind rehabilitation skill areas for which the BROS instructor is not already proficient. Much of this instruction can be provided at the regional BRC.

(3) Activities that encourage teamwork and facilitate communication between the BROS and other BRS field staff.

(4) A mentoring program under the oversight of an established BROS and a National Program Consultant.

(5) An orientation to the duties and responsibilities of the VIST Coordinator and creation of collaborative protocols for serving the blinded veterans in their area.

(6) Training on the VA organizational structure, policy and procedures will be provided at the BROS' local facility.

### **14. BROS PROFESSIONAL COMPETENCIES**

a. BROS must have professional training and skills in two of the three rehabilitation areas listed below. The educational requirements and expected competencies for each of these areas are:

(1) **Orientation and Mobility.** Requires a BROS with a degree from an accredited college or university and who has met the core curriculum requirements in orientation and mobility, and has completed a supervised orientation and mobility internship.

(2) **Living Skills (vision rehabilitation therapy).** Requires a BROS with a degree from an accredited college or university and who has met the core curriculum requirements in vision rehabilitation therapy, and has completed a supervised vision rehabilitation therapy internship.

(3) **Visual Skills (low-vision therapy).** Requires a BROS with a degree from an accredited college or university and met the core curriculum requirements in low-vision therapy, and has completed a supervised low-vision therapy internship.

b. Polytrauma BROS must meet their two journeyman areas of expertise requirements in orientation and mobility and low-vision therapy.

c. In addition to the two areas of advanced technical knowledge and competence, BROS are expected to be knowledgeable of all components of a comprehensive blind rehabilitation program (i.e., orientation and mobility, living skills, visual skills, manual skills, and computer access) in order to provide services in all areas of blind or low-vision rehabilitation.

d. BROS are expected to maintain their expertise by attending all BROS training provided by Blind Rehabilitation Service (BRS)-VA Central Office, as well as other training providing within and outside VHA.

## 15. PROGRAM OVERSIGHT

a. **VHA Blind Rehabilitation Service Oversight.** National Program Consultants perform ongoing review and evaluation of BROS programs to ensure that blind rehabilitation outpatient services are being provided in an effective and efficient manner.

b. **Consumer Feedback and Input.** In coordination with the local VIST Coordinator, BROS establish a mechanism to solicit blind and visually-impaired veteran feedback and input concerning the overall quality of care and services provided to them. This can be accomplished by periodic surveys, consumer forums, and input from local Blinded Veterans Association and other consumer group representatives.

## 16. RECRUITMENT AND PROMOTION

a. In a health care facility where a BROS position exists or is to be established, the position should be organizationally aligned under the Chief of Staff. The BROS positions are advertised at the medical center in which the position resides. Positions are Hybrid Title 38 positions and require a VA BRS Professional Standards Board (PSB) review and recommendation.

b. Although the full performance level position is at the GS-12, recruitment may be at the GS-11 level. The position may be filled non-competitively at the target grade by reassignment of eligible candidates or qualified higher level candidates may change to the lower grade. The position may also be filled by qualified candidates eligible for excepted appointments under the Schedule A, and the '30 Percent' Disabled Veteran Appointment Authorization.

c. Promotion to the target grade will depend on professional competence, performance and program development.

d. Each health care facility having a position identified as Blind Rehabilitation Outpatient Specialist, GS-601-11, or GS-601-12, must ensure that the position description or functional statement reflecting the position's organizational alignment under the Chief of Staff, is current and available upon request.

e. The facilities must notify BRS, VHA Central Office of vacancies in BROS positions, requesting assistance in recruitment. The recruiting facility determines the grade level at which the position will be filled and forwards the name of the appropriate candidate to the PSB for review.

f. In order to promote the incumbent to the full performance level, the facility must obtain the approval of the VA BRS PSB.

## 17. REFERENCES

a. Optometric Clinical Practice Guidelines, American Optometric Association at: (<http://www.aoa.org/x4813.xml>)

b. Preferred Practice Patterns, American Academy of Ophthalmology at: (<http://one.aao.org/CE/PracticeGuidelines/PPP.aspx>)

c. Social Security Disabilities Programs, Medical/Professional Relations, Disability Evaluation under Social Security, Section 2.00 Special Senses and Speech, Statutory Blindness at: (<http://www.ssa.gov/disability/professionals/bluebook/2.00-SpecialSensesandSpeech-Adult.htm>)

d. Veterans Benefits Administration, Fast Letter 06-21, Measurement of Visual Fields.

e. VHA Handbook 1173.5, Aids for the Blind.

f. VHA Handbook 1173.2, Furnishing Prosthetic Appliances and Services.

g. VHA Handbook 1172.1, Polytrauma Rehabilitation Procedures.

h. VHA Handbook 1173.12, Prescription Optics and Low-Vision Devices.

i. VHA Handbook 1121, VHA Eye Care.

j. VHA Prosthetic Clinical Management Program (PCMP) Clinical Practice Recommendations for Audible Prescription Reading Devices.

k. VHA Prosthetic Clinical Management Program (PCMP) Clinical Practice Recommendations for Prescription of Closed Circuit Televisions (CCTVs) and Other Electronic Optical Enhancement Devices (EOED).

l. VHA Prosthetic Clinical Management Program (PCMP) Clinical Practice Recommendations for Prescription and Provision of Daily Living and Mobility Devices for Legally Blind and Visually-Impaired Veterans.

m. VHA Prosthetic Clinical Management Program (PCMP) Clinical Practice Recommendations on Prescription and Provision of Optical Low-Vision Devices to Aid in Overcoming Visual Impairment.

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