REPORT OF THE SECRETARY OF HEALTH
AND HUMAN RESOURCES

EVALUATING THE IMPLEMENTATION OF THE RECOMMENDATIONS OF THE COMMISSION ON THE COORDINATION OF THE DELIVERY OF SERVICES TO FACILITATE THE SELF-SUFFICIENCY AND SUPPORT OF PERSONS WITH PHYSICAL AND SENSORY DISABILITIES

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 73

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TO: The Honorable George Allen

and

The General Assembly of Virginia

The report contained herein is pursuant to House Joint Resolution 83, agreed to by the 1994 General Assembly.

This report constitutes the response of the Secretary of Health and Human Resources, "to evaluate the implementation of the recommendations made by the Commission on the Coordination of the Delivery of Services to Facilitate the Self-Sufficiency and Support of Persons with Physical and Sensory Disabilities."

Respectfully submitted,

Brian S Parsons

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Director

Preface

In the 1992 Report of the Commission on the Coordination of the Delivery of Services to Facilitate Self-Sufficiency and Support of Persons with Physical and Sensory Disabilities (Disability Commission), it was recommended that the Secretary of Health and Human Resources conduct an evaluation in 1995 of the Commission's efforts. To address this recommendation, the 1994 General Assembly approved House Joint Resolution 83 (HJR 83). A Task Force, comprised of consumers, representatives of disability services boards, and local service providers, was appointed by the Secretary of Health and Human Resources to assist in planning and conducting the evaluation. Over a series of meetings during the Fall of 1994, the Task Force developed a comprehensive evaluation plan which was subsequently implemented in 1995.

The document which follows reports on the impact of Commission efforts which were studied, and suggests potential modifications for future Commission driven activities aimed at improving service delivery for citizens of the Commonwealth with physical and sensory disabilities.

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Special acknowledgement is given of the important contribution made to this study by the many individuals with sensory and physical disabilities who participated throughout the Disability Commission evaluation process.

Table of Contents

Executive Summary

The 1992 Report of the Commission on the Coordination of the Delivery of Services to Facilitate Self-Sufficiency and Support of Persons with Physical and Sensory Disabilities (Disability Commission) recommended that in 1995 the Secretary of Health and Human Resources undertake an evaluation of Disability Commission activities to determine the impact of its efforts and identify potential modifications to future Commission activities. During the 1994 General Assembly, House Joint Resolution 83 (HJR 83) was approved requesting the Secretary to evaluate the implementation of recommendations made by the Disability Commission. Pursuant to the resolution, the Secretary of Health and Human Resources formed a task force comprised of consumers, representatives of disability services boards, and local service providers to assist in planning and conducting the evaluation. The Virginia Board for People with Disabilities provided staff support for the Task Force. Over a series of meetings in the Fall of 1994, the Task Force developed a comprehensive evaluation plan which was subsequently implemented in 1995.

To insure that the evaluation plan directly responded to the intent of HJR 83, the Task Force focused its activities in five areas:

1. The Disability Services Council and Disability Services Board network;
2. Prior and current funding initiatives of the Disability Commission;
3. Current interagency committees, task forces, and work groups addressing the needs of individuals with disabilities;
4. Information and referral systems operated by state and local agencies;
5. Administrative recommendations contained in the initial report of the Disability Commission.

Evaluation of the Disability Services Council and the Disability Services Boards

The results of the evaluation of the Disability Services Boards (DSB) and the Disability Services Council (DSC) provide a picture of a service coordination system still in its early stages of growth and development. DSBs have primarily focused their activities on transportation services, accessibility issues, conducting their needs assessments, improving services for individuals with hearing impairments, and housing issues. Increasing community awareness, enhancing community services, and developing a Rehabilitative Services Incentive Fund proposal are identified most frequently as DSB accomplishments.

DSC members are clearly aware of the issues and challenges facing the Disability Services Boards. They emphasize the need for Boards to find active and committed members. The Council recognizes that the Boards are at various stages in their development and believe that an organization of DSBs would further assist the Boards in providing support and technical assistance through the exchange of ideas and information.

Findings and Conclusions

1. **There is wide variation across the state as to the development and implementation of the Disability Services Boards.**

2. **The DSC members believe that the DSBs are meeting their original purpose and should not be redefined.**

3. **Greater sharing of information between the DSC and the DSBs needs to be accomplished in an effective and timely manner.**

4. **The DSB members need further clarification and refinement of their responsibilities and authority.**

5. **Local government has been supportive of the DSBs' efforts to establish the Boards and implement their activities.**

6. **The DRS liaison plays a key role in providing the DSBs information and an understanding of the other organizations and agencies involved with the Boards.**

7. **The DSC believes that an organization of DSBs would further assist the Boards in providing support and technical assistance.**

Evaluation of Funding Initiatives

Consumer Services Fund

The guidelines established for the Consumer Service Fund are responsive to its intended purpose. Approximately 190 applications per year are received for funding. The application review process effectively screens applications for need based on the 'fund of last resort' principle that guides the Consumer Services Fund. The allocation to the Consumer Service Fund is fully utilized to provide a wide array of services to a population representative of persons with physical and sensory disabilities.

Findings and Conclusions

1. **The Consumer Services Fund is effectively managed and appears to be fulfilling its intended purpose.**

2. **Because of the short term nature of service intervention through the Consumer Services Fund, it is difficult to evaluate the longer term impact of these services.**

3. **Complete information is not available regarding the specific number of unfunded applications that met funding criteria but were turned down by the CSF screening committee because of lack of funds.**

Rehabilitative Services Incentive Fund

A comprehensive evaluation of the impact to date of the Rehabilitation Services Incentive Fund (RSIF) is not possible because this program is currently in the process of completing the initial funding of awards to Disability Services Boards. All implementation activities to date are supportive of the RSIF achieving its purpose. It is important to note that the $500,000 RSIF appropriation leverages additional funds and support at the local level through the match process. For FY 1996, the first year of RSIF funding, that match total will be over $300,000.

Findings and Conclusions

1. **In a number of instances, the RSIF DSB allocations and award levels involve small amounts of funds. Consideration is needed as to whether the $1,000 minimum allotment for a DSB establishes a "critical mass" of funds to allow for a significant impact on rehabilitation services in a community.**

2. **The RSIF is consistent with the DRS effort to decentralize services and to support community service development.**

Personal Assistant Services

The Personal Assistance Services program served 105 individuals with disabilities during Fiscal Year 1995. There are 300 individuals who are on a waiting list to receive services. The consumers who participate in the DRS Personal Assistance Services program have significant disabilities and are likely to have a health condition or existence of a disability other than their primary disability. These participants receive more paid hours of care than those individuals on the PAS waiting list and do not spend a significant portion of their personal funds to receive these services. Because those on the waiting list spend a substantially higher percentage of their own funds on personal assistance, the data suggest that the PAS program helps reduce a significant financial liability on the consumer, as well as provide support to unpaid family caregivers.

Findings and Conclusions

1. **The PAS program has a dramatic impact on the independence and productivity of participants.**

2. **While available to individuals in all areas of the state, the PAS program is only meeting a small percentage of the identified need.**

Long Term Case Management Program

The Long Term Rehabilitative Case Management (LTRCM) Program has been in place since 1989. Two separate studies were completed in FY 1994 involving LTRCM participants. Approximately 78% of persons surveyed reported being completely satisfied with the services received. Results of the second study indicated that LTRCM participants were linked to an average of four more service resources (13.9 compared to 9.3) than individuals on the waiting list.

Findings and Conclusions

1. **The Long Term Case Management Program is assisting approximately 140 persons with physical disabilities access a wide array of community based rehabilitation services at a cost of approximately $2,000 - $2,500 per person per year.**

2. **Recent program data indicate that the LTRCM Program is able to assist approximately 20-25 new participants per year.**

Cognitive Rehabilitation Program

The Cognitive Rehabilitation Program (CRP) is providing cognitive rehabilitation services to individuals consistent with the targeted population and program purpose. On balance, the response to the program by service recipients, service providers, and other participants is positive. CRP representatives have taken appropriate steps to strengthen the program based on the formal evaluation of the first year (FY 1994) outcomes.

The Cognitive Rehabilitation Program does appear to be achieving its purpose of assisting individuals with an acquired brain injury to achieve greater community integration, live in a less restrictive environment and move forward in their rehabilitation process. It is difficult, however, to factor out specifically the contribution of cognitive rehabilitation services within the entire array of services provided to program participants.

Findings and Conclusions

1. **Funds for this program are used to purchase cognitive rehabilitation services.**
2. **The annual appropriation for the CRP program is $200,000, and services are provided to 6-8 individuals.**

Evaluation of the Accomplishments and Effectiveness of State-Level Interagency Committees

The myriad of interagency committees that currently exist in the Commonwealth must be judged independently, as opposed to assessing the impact of collaborative efforts as a whole when examining state agency activities during the past few years. A vehicle for interagency collaboration and cooperation, the Plan of Cooperation, did operate from 1986 until several years ago. While inactive, the Plan of Cooperation Committee has not been formally disbanded. Consideration should be given as to whether current interagency communication channels are sufficient, or whether the Plan of Cooperation Committee should be revitalized.

Findings and Conclusions

1. **Many interagency boards, committees, councils, and workgroups currently exist that have accomplished many of the objectives of the Disability Commission.**
2. **The Plan of Cooperation, a focal point of interagency collaboration identified within the original Disability Commission report, is definitely not active, but the reasons for this are not clear.**

Evaluation of the Efficiency of Existing Information and Referral (I & R) Programs

It is clear that consumers can get excellent information from very helpful people who answer the telephones at the I&R systems that were examined in this study. But other consumers can call the same I&R system with a similar need and receive very little information. There exists variability in scope of information, role of the person receiving the request for information, and data availability. Better preparation of staff and easily accessible resource information would certainly improve consistency within each system.

Findings and Conclusions

1. **Currently, there does not exist a statewide I&R system capable of handling all of the potential calls from individuals with sensory and physical disabilities.**

2. **By all accounts the state's present information and referral network is only addressing a fraction of the current needs.**

Evaluation of the Implementation of Commission Administrative Recommendations

Significant action has been taken to implement a large number of the recommendations contained in the original Disability Commission Report. Pilot projects and direct services have been expanded; existing resources have been creatively used to increase access to needed services and equipment; and interagency collaboration continues, although perhaps not always on a formal or consistent basis.

Findings and Conclusions

1. **The administrative recommendations contained in the original Disability Commission Report stimulated a great deal of activity among Virginia state agencies.**

2. **It would be beneficial to examine the recommendations that did not receive a response from the state agencies responsible for implementation.**

Introduction

The 1992 Report of the Commission on the Coordination of the Delivery of Services to Facilitate Self-Sufficiency and Support of Persons with Physical and Sensory Disabilities (Disability Commission) created a blueprint for the design, implementation and evaluation of a comprehensive service delivery system for individuals who previously had been denied the services and supports necessary to maximize their independence and productivity. The Commission proposed a ten year plan which emphasized consumer-focused services which are developed and implemented at the local level. Local planning capacity was addressed through the creation of a system of local Disability Services Board guided by a Disability Services Council. Several service programs were identified for expansion. Multiple administrative recommendations were developed that were designed to eliminate barriers to service delivery and coordination. The Report recommended that in 1995 the Secretary of Health and Human Resources undertake an evaluation of Commission's efforts to determine the impact of Commission efforts and identify potential modifications to future Commission activities.

During the 1994 General Assembly, a joint resolution was approved requesting the Secretary of Health and Human Resources to evaluate the implementation of recommendations made by the Commission on the Coordination of the Delivery of Services to Facilitate the Self-Sufficiency and Support of Persons with Physical and Sensory Disabilities, which is referenced as the Commission or the Disability Commission. HJR 83 outlined the areas of the evaluation to assess the effectiveness of the recommendations advanced by the Disability Commission including, "(i) **the Disability Services Council and the disability services boards,** (ii) **the impact of new funding on the availability of services for persons with physical and sensory disabilities,** (iii) **the accomplishments and effectiveness of state-level interagency committees that address service issues including the Plan of Cooperation established in the Virginians with Disabilities Act,** (iv) **the efficiency of existing Information and Referral (I&R) programs in providing an effective point of entry and in meeting the transition and continuing service needs of consumers,** and (v) **the implementation of Commission recommendations for administrative action by involved state agencies."**

Pursuant to the resolution, the Secretary of Health and Human Resources formed a task force comprised of consumers, representatives of disability services boards, and local service providers to assist in planning and conducting the evaluation. The Virginia Board for People with Disabilities provided staff support for the Task Force. Over a series of meetings in the Fall of 1994, the Task Force developed a comprehensive evaluation plan which was subsequently implemented in 1995.

To insure that the evaluation plan directly responded to the intent of HJR 83, the Task Force focused its activities in five areas:

1. The Disability Services Council and Disability Services Board network;
2. Prior and current funding initiatives of the Disability Commission;
3. Current interagency committees, task forces, and work groups addressing the needs of individuals with disabilities;
4. Information and referral systems operated by state and local agencies;
5. Administrative recommendations contained in the initial report of the Disability Commission.

This report summarizes the methodology used to complete the evaluation and the results of the evaluation in each of the five areas. A preliminary version of the report was prepared and reviewed by appropriate individuals for technical accuracy and completeness. After this preliminary verification process was completed, a final report section was added which contains the major findings and conclusions resulting from the evaluation process.

Evaluation of the Disability Services Council and the Disability Services Boards

The evaluation of the implementation of the Disability Commission's recommendations and initiatives included an assessment of the Disability Services Council (DSC) and the Disability Services Boards (DSBs). To ensure that a comprehensive review of the DSC and the DSBs was completed, four separate evaluation activities were implemented. These methods included (1) an evaluative review of DSC and DSB records and administrative materials maintained by the Department of Rehabilitative Services, (2) a series of structured telephone interviews with DSC members, (3) completion of a written survey by DSBs, and (4) a series of structured telephone interviews with a random sample of DSB members.

Evaluative Review of DSC and DSB Documentation

An evaluative review was conducted of existing minutes, records, reports, and other pertinent documentation of the Disability Services Council and the Disability Services Boards. An analysis using open-ended review techniques was performed assessing the following areas: a) administrative characteristics of DSBs; b) DSB applications for Rehabilitation Services Incentive Funds; c) Self-reported accomplishments of each DSB; d) composition of the DSC; e) DSC correspondence with other state agencies, f) correspondence between the DSB and the DSC; and g) DSB needs assessment updates.

The information compiled through this document review has been used to summarize information related to the Rehabilitation Services Incentive Fund and the results of the DSB needs assessments. In addition, these materials were used to develop the DSC telephone survey and the written DSB survey. Information from the review was also used to supplement the DSBs' written responses to questions pertaining to composition and function of the local DSBs.

Telephone Interviews with Disability Services Council Members

The evaluation of the implementation of the Disability Commission's recommendations and initiatives included detailed telephone interviews with members of the Disability Services Council (DSC). The evaluation results described in this section of the report were obtained through structured telephone interviews. Specifically, the telephone survey was designed to investigate Council members' perceptions in the following areas:

- structure of the DSC, including membership and administrative and staff support;

- communication with other state agencies, Disability Services Boards, and the Department of Rehabilitative Services;

- accomplishments of the Disability Services Council and the Disability Services Boards;

- issues facing the Disability Services Boards;

- effectiveness of the Boards in meeting their legislative mandates; and

- factors that influence the effectiveness of the Disability Services Boards.

Method - The questions for the telephone survey were developed based on the results of a structured file review of DSC materials. Materials obtained through this review were used to construct 16 open-ended questions, enabling members to express what they believed was important about their experiences with the Council. Two trained telephone interviewers were used to conduct the survey with the Council members.

Results - A majority of the DSC members have served on the Council for approximately one year. One member has served for three years. When asked what they believe has been the DSC's greatest accomplishment, most of the members reported establishing the Rehabilitation Services Incentive Fund grant allocation system.

When asked to describe the quality of administrative and staff support provided the DSC, most respondents felt that the support provided to the Council had been thorough and responsive. One respondent indicated that the liaisons have been dedicated and enthusiastic. When asked how the support could be improved, two of the members felt that more time was needed to provide information and training to the new members. Other comments included the need for members to be more involved in decisions that impact the DSC and DSBs, more funds to provide staff support to the Council, and more time for liaisons to perform their duties with the local DSBs.

All of the members responded that the DSC is comprised and implemented as planned. When asked if the Council included the most appropriate members, four of the respondents said yes. Two members felt that further assurances of participation from the Department of Education were needed. One member responded no, questioning the advisability of including the Superintendent of Public Instruction on the DSC. This respondent felt that while the DSC deals with issues that impact the schools, there are issues that equally impact other state agencies, such as transportation, housing, and medical services. It was suggested that in addition to the Department of Education, representatives from Virginia Department of Transportation, Virginia Housing and Development Authority, and Department of Medical Assistance Services be appointed to the Council.

The Council members were asked if the originally intended level of support has been met or exceeded by the Disability Services Boards, Department of Rehabilitative Services and other state agencies. One respondent felt that the question could not be sufficiently answered since the Code of Virginia does not indicate any specific level of support, but rather lists specific functions. One Council member felt that as a whole the DSBs have done well. Three of the members responded no, stating that (1) there is a lack of communication between the DSBs and DSC, (2) the Boards need further financial assistance to fulfill their intended purpose, and (3) the extent to which the DSBs have been able to become established varies across the state.

When asked about the level of support provided by the Department of Rehabilitative Services, four of the members felt that the support has been good and has gone beyond the original intent of providing staff support to the DSBs. One comment made by a Council member was that despite being overworked and having few resources, the DRS liaisons had done a splendid job. One member felt that better communication was needed between the Council and DRS.

Three of the members felt that other state agencies have been actively participating in Council activities. When contacted by the DSC, state agencies have been helpful and timely in their responses. Two members did not respond to the question. One member did, however, comment that the question could not be answered because there are no stated expectations of other agencies in the Code of Virginia.

The Council identified several issues that the DSBs are currently addressing. Their responses included: 1) lack of funds to meet their goals, 2) transportation for individuals with disabilities, 3) identifying service needs in their localities, 4) recruitment of active members and recruitment of individuals with disabilities to serve on Boards, 5) lack of communication among DSBs, and 6) lack of certified interpreters in rural areas requiring the cancellation of events and meetings due to accommodation needs.

The survey respondents were asked what they thought were the DSBs' greatest accomplishments. Most of the members felt that conducting the needs assessments in their localities, increasing the awareness of individuals with disabilities about available resources in their area, and educating the public about the ADA were major accomplishments. Two members stated that the establishment of DSBs across the state was a significant accomplishment helping to create a direct link with local government.

The Council members were asked about the funds appropriated to each DSB. One survey participant felt that the question was misleading, responding that the General Assembly appropriates the funds to the Department of Rehabilitative Services which in turn distributes it to the various DSBs. Two of the Council members responded that the funds were sufficient. Two other members felt that the funds were not adequate. One Council member felt that if the DSBs used the services of an interpreter, they would exceed their budgets. Another member commented that with additional funds the DSBs could further address critical needs in their localities.

When asked if they believe there should be a variation in the funding based on the DSB's locality, four of the Council members responded yes. Their comments focused on the need to study the DSBs' funding mechanism based on a locality's population distribution, the needs of particular groups of individuals, and the availability of local sources of financial support. One of the Council members could not respond to the question, since the funding provided to the DSBs is for the administration of the Board and not for services. Therefore, it should not be based on a locality's population.

The Council members believe that the information obtained through the DSBs' needs assessment has been useful. The members felt that the information has been used by the DSBs to assist in their local planning and for developing their Rehabilitation Services Incentive Fund applications.

When asked whether the DSBs and the Council share information in an effective and timely manner, three of the Council members responded no. Their responses focused on the need for support services to be more organized and more education of DSB members is needed to help facilitate the communication. Two of the respondents felt that the communication is good and has improved over time.

Most of the Council members believe that the DSBs are meeting its original purpose. They believe that most Boards are making a sincere effort to educate the public and recognize that the Boards are at various stages in their development and ability to fully carry out their legislative mandates. Two of the members felt that more needed to be done. Their concern is that many consumers are still not aware of the existence of DSBs in their localities.

The Council members believe that the role or function of the DSBs should not be redefined. The members feel there is a need for clarification of the DSBs' role and a need to include more consumers. However, the members believe that the Boards are still in the formative stage and need more time to develop and become established.

When asked about whether the Boards have been able to secure the membership as originally planned, the members responded that the Boards have achieved mixed results. The Council members acknowledged that most Boards have been able to secure their membership as mandated, however, they also realize that the Boards have had difficulty in obtaining consumer involvement and leadership. The Council members also indicated problems recruiting Board members from the business community and local government. The Council members believe that the overall representation on the Boards is appropriate.

The Council members provided a variety of comments concerning the key ingredients needed for establishing an effective Board. They believe that Boards should identify individuals who will be active participants. They also felt that close communication between the locality and the disability community is important. Several members commented on the need for the Boards to engage in media and publicity activities in their communities to enable the public to learn about the DSBs and their purpose.

All of the Council members felt that the creation of a statewide association of DSBs would be helpful. They expressed the opinion that an association could enable members to exchange ideas and information, network with other DSBs, provide technical assistance and support to the Boards, and help to establish a political presence.

The final question on the survey asked the Council members what recommendations they would make to the Disability Commission to further strengthen the role of the DSBs. The Council members expressed various recommendations which included:

- Clarification of the DSB's role;
- Provide recognition, encouragement, and political support to the DSBs;
- Use the most effective DSBs as models for other DSBs to assist in the development of goals and implementation plans;
- Re-examine the provisions of the legislation that defines staff support to the Boards.

<u>Conclusion</u> - A majority of the DSC members have served on the Council for one year. When asked what they believe has been the Council's greatest accomplishment, most members responded establishing the Rehabilitation Services Incentive Fund grant allocation system.

The Council members believe that more needs to be done to insure that the DSC and DSBs share information in an effective and timely manner. Their responses focused on the need for support services to be more organized and more education of DSB members about the Council.

Most of the members interviewed felt that other state agencies have been actively participating in Council activities. When contacted by the DSC, state agencies have been helpful and timely in their responses.

The Council members believe that the information obtained through the DSBs' needs assessment has been useful. The members felt that the information has been used by the DSBs to assist in their local planning and for developing their Rehabilitation Services Incentive Fund applications.

The DSC is aware of the issues and challenges facing the Disability Services Boards. Their responses describe the need for Boards to find active and committed members. They realize that the Boards are at various stages in their development and believe that an organization of DSBs would further assist the Boards in providing support and technical assistance through the exchange of ideas and information.

Statewide Survey of the Disability Services Boards

A written informational survey was developed and mailed to each DSB chairperson. The survey was designed to obtain information in such areas as the jurisdiction which the Boards serve, the frequency of local Board meetings, administrative support and other resources provided to the DSBs, and the major activities with which the Boards have been involved over the past 12 months.

Twenty-seven of the DSBs responded to the survey. The information described in this section of the report is based an analysis of the comments provided by 26 of these Boards. One survey was incomplete because the DSB is still trying to become established, so information about their activities was unavailable.

Most of the DSBs are meeting monthly and have obtained the necessary representation on their Boards. A majority (58%) of the DSBs who responded represent multiple jurisdictions. The other most frequently reported jurisdiction was single county (38%). The vast majority of Boards have not considered any changes in the jurisdiction which they represent. However, five Boards indicated that they had either joined a regional board, joined with several other counties, or split into two separate Boards because of the distance the members had to travel. The type of jurisdictions represented by survey respondents are summarized in Table 1-1.

Well over half of the DSBs receive administrative support from local governments in the form of staff time and printing and mailing costs. The Boards' also reported sufficient support in terms of office space for conducting meetings, dissemination of resources and materials, and performing other routine Board activities. When analyzing their responses, it is apparent that the majority of the space provided to the Boards is for meetings only.

When asked to describe their relationship with their local Mayor's Committee for People with Disabilities, only five DSBs were familiar with this organization.

Table 1-1
Jurisdiction Representation
N=26

Jurisdiction	Percent
Multijurisdictional	58
Single county	38
Single city	4

Most of the DSBs (36%) responded that increasing the awareness of disability-related issues in their communities was their greatest accomplishment. Other accomplishments reported by the survey respondents included applying for the Rehabilitation Services Incentive Fund (32%), developing their needs assessment (16%), providing information on the ADA or working with their localities on ADA related issues (16%), and increasing the awareness in their community about the DSBs (16%). Most frequently reported DSB accomplishments are summarized in Table 1-2.

Table 1-2
Most Frequently Reported DSB Accomplishments
N=25

Accomplishments	Percent
Increased community awareness	36
Developing Rehabilitative Services Incentive Fund (RSIF) grant proposal	32
Conducting needs assessment	20
Addressing transportation issues	16
Conducting ADA information and referral activities	16
Establishing DSB	16

The DSBs were asked to describe their information and resource referral activities during the past year. A majority of the Boards reported a range of activities they have conducted including developing brochures to publicize the DSB, developing a resource guide, providing information for newspaper articles, and speaking at various community organizations. A number of Boards indicated that they devote between 20% to 30% of their time to these types of activities.

The DSBs were asked to describe their activities to meet the goals and objectives identified in their six-year plan. All but two of the Boards identified a number of activities focusing on the ADA, establishing relationships with existing CILs or attempting to create a new CIL, expanding services for individuals with hearing impairments, and working on such issues as transportation and housing.

All but three of the respondents submitted an application for the Rehabilitative Services Incentive Fund. Almost 60% responded that they received technical assistance from DRS when developing the application. Approximately one-third of the Boards indicated that they could benefit from additional technical assistance. The type of assistance identified by the Boards focused on the need for additional instruction in the completion of the Incentive Fund application, for example more concise instructions on the guidelines.

The DSBs were asked to describe their level of communication with the Department of Rehabilitative Services. Responses ranged from quarterly to several times a month. The nature of the contacts is quite varied, including requests for information, on-going discussion of current projects, data dissemination, and meeting coordination and agendas.

When asked if they had any suggestions to enhance the support and assistance provided by DRS liaisons to DSBs, the respondents were almost evenly divided. Over half (52%) of the respondents stated no to this question. Those who responded yes (48%) clearly indicate that the Boards view their liaisons as the primary communication link with DRS and they would like to see this relationship strengthened either through an increase of liaison time spent with the Board or through training which would enable the liaisons to better understand their role.

Approximately 60% of the respondents believe that additional services or supports are needed from DRS to enable the DSBs to meet their responsibilities. Suggestions included additional staffing, and the need for a statewide DSB forum to share information and obtain insights and ideas from other Boards across the state.

The respondents were asked if there was other information they would like to add as part of the survey. Half submitted responses, which included slow response at the state level to DSB questions or concerns, problems with attendance and reappointment of DSB members, and more timely communication from DRS and the DSC.

Conclusion

Results of the written DSB survey are based on approximately 60% of the Boards. Most respondents represent multiple jurisdictions Boards and are meeting on a regular basis. The DSBs do not have a specific location to perform their responsibilities, but are provided space by their localities for meetings. Over half of the DSBs receive administrative support from local governments in the form of staff time and mailing costs.

Most of the DSBs participating in the survey believe their greatest accomplishment has been the increased awareness of disability-related issues in their communities. The Boards described a number of activities they have conducted to fulfill their information and referral responsibilities. A number of the Boards estimated that between 20 to 30 percent of their time is devoted to these types of activities.

A range of responses was provided by the Boards when asked about their level of communication with the Department of Rehabilitative Services. The nature of the contacts is quite varied, including requests for information, on-going discussion of current projects, data dissemination, and meeting coordination and agendas. Almost half of the respondents provided suggestions for enhancing the support and assistance provided by their DRS staff liaison. Their suggestions clearly indicated that the Boards view their liaisons as the primary communication link with DRS and they would like to see this relationship strengthened through either an increase of liaison time allocated to the Boards or through increased training of the liaisons to enable them to better meet their responsibilities with the DSBs.

A majority of the survey participants believe that additional services or supports are needed from DRS to enable them to meet their responsibilities. Suggestions included additional staffing and the need for a statewide DSB forum.

The Boards expressed the desire for more timely communication between the DSBs and the DSC and DRS. They believe they are not getting the information that they need to address their questions and concerns. They also expressed problems with attendance at their meetings and the reappointment of DSB members.

Telephone Interviews with DSB Members

A major component of the overall evaluation of the DSC and the DSB was the completion of in depth telephone interviews with a random sample of 85 members of local Boards. Specifically, the interviews were intended to investigate the following questions:

- What is the level of support provided to the Boards from the Department of Rehabilitative Services, Disability Services Council, and local government?

- What issues are the Boards addressing in their localities and what do they view as their greatest accomplishments?

- How have the Boards been able to meet their mandated responsibilities, including appointing their members, conducting and updating a needs assessment for their locality, and performing their ADA information and referral activities?

- Should the role and function of the DSBs be redefined?

- What are the key ingredients needed for establishing an effective DSB?

Method

The questions for the telephone survey were constructed from input provided by Disability Services Board members. Disability Service Board chairpersons were contacted and asked to select a member from their Board to attend a regional focus group to discuss questions for the survey. Three focus groups were held in various sections of the state with the participants providing input on what questions should be asked. The outcome of these groups was the development of a survey consisting of fourteen questions. The questions were primarily open-ended, allowing the respondents an opportunity to express what they believed was important about their experiences with the DSBs.

After the development of the survey, the Department of Rehabilitative Services provided a list of current DSB members. A random sample was drawn, selecting the names of 85 members, representing approximately a quarter of the current DSB membership.

The names drawn through the sample were divided among three trained telephone interviewers. The DSB members were called and the interviewer explained the purpose of the survey and requested the respondent's participation. The interviews were conducted during a time convenient for the DSB member.

Participants

The telephone survey was conducted with 42 individuals who represented individuals with physical and sensory disabilities and family members on the Boards. Eleven of the participants were from the business community and 32 were local government officials. Table 1-3 identifies the number of respondents from each of the three major constituency groups on the DSBs.

TABLE 1-3
Survey Respondents
N = 85

CONSTITUENCY	FREQUENCY	PERCENT
LOCAL GOVERNMENT OFFICIAL	32	38
INDIVIDUAL WITH A DISABILITY/FAMILY MEMBER	42	49
BUSINESS	11	13

Participant Characteristics

The majority of DSB members interviewed represented individuals with disabilities and family members. Most of the survey participants have been appointed to three year terms. When asked how long they have currently served on their Boards, half of the respondents reported two years. Table 1-4 identifies the length of time each respondent has served as a member of a DSB.

TABLE 1-4
Length of Time Currently Served on DSB
N = 83

TERM SERVED (YEARS)	FREQUENCY	PERCENT
LESS THAN 1	6	7
1	18	22
2	43	52
3 & OVER	16	19

The DSB members were asked if they had a clear understanding of the Board's purpose and role when they began their term as a member. Over half of the respondents said yes. However, 46% of the survey participants felt that when they became members, they did not have a complete understanding of (1) their role as a Board member and (2) the overall purpose and function of the DSB. Some of the participants commented that there was not enough training to orient new members and that the purpose of the Board was never clearly defined. Others commented that they learned more about the Board and their role after attending several meetings. When asked if they have been provided all of the information that they need to carry out their Board responsibilities, a majority (84% of the sample) said yes.

DSB Activities

The next two questions on the survey asked the members to describe the major issues their Boards are currently addressing and their greatest accomplishments. Approximately 40% of the respondents identified transportation as the major focus of their Board's activities. A quarter of the survey participants identified accessibility issues (specifically making buildings accessible or services in the community). Twenty-four percent of the respondents also reported conducting/updating their Board's needs assessment as a major concern.

Fourteen percent of the respondents identified Board activities focusing on enhancing services for individuals with hearing impairments. Examples of this type of activity included establishing a deaf awareness program, implementing a training program for interpreters, and applying for funds to obtain assistive devices. Another issue frequently identified by DSB members was housing (13%), including the availability of accessible housing for individuals with physical disabilities. The major issues most frequently reported as addressed by DSB are delineated in Table 1-5.

TABLE 1-5
Major Issues Most Frequently Addressed by DSBs
N = 85

ISSUES	PERCENT
TRANSPORTATION SERVICES	41
ACCESSIBILITY/BARRIERS IN COMMUNITY	24
CONDUCTING/UPDATING NEEDS ASSESSMENT	24
SERVICES FOR INDIVIDUALS WITH HEARING IMPAIRMENTS	14
HOUSING	13

Table 1-6 summarizes Board member responses when asked about their Board's greatest accomplishments. Over one-third (35%) of the members reported increasing public awareness and education about people with disabilities. This has been accomplished through public forums, personal contacts in the community by Board members, and information distributed through brochures and in the newspaper. Twenty percent (20%) of the respondents reported that preparing and updating their local needs assessment reports has been a major accomplishment of their Boards. Fifteen percent of the respondents identified specific projects that have been developed and implemented by the DSBs in their localities. Examples of these unique activities included purchasing a van for transportation, collecting walkers, canes, and wheelchairs for individuals in need, and establishing a resource center for individuals with hearing impairments.

TABLE 1-6
Most Frequently Reported DSB Accomplishments
N = 85

ACCOMPLISHMENTS	PERCENT
INCREASED COMMUNITY AWARENESS	35
CONDUCTING/UPDATING NEEDS ASSESSMENT	20
ENHANCING COMMUNITY SERVICES	15
DEVELOPING INCENTIVE GRANT PROPOSAL	11
ESTABLISHING DSB	7

DSB Organizational Structure

Several questions on the survey focused on the relationship of the DSBs with the Department of Rehabilitative Services, and the level of support the Boards have received from the Department and from the Disability Services Council and local governments. The first question asked the members whether they believed the relationship between the Boards and DRS should be redefined. Almost two-thirds of the respondents answered yes. Board members stated that there needs to be enhanced communication between DRS and the DSBs, with more timely responses to requests for information. Respondents also expressed confusion about the Department's role with the Boards, indicating their need for clarification about how much assistance and guidance the DSBs can request. Approximately 40% of the survey participants did not believe their relationship with DRS should be redefined. It should be noted that the primary reason that these respondents did not see the necessity for a change was their relationship with the DRS liaison. Their comments clearly indicated a positive and supportive relationship with their individual liaison, which enabled the Board members to obtain information and guidance during the development of the Board.

The respondents were asked if they believed that the original level of support (for example, staff, finances, or commitment) has been met or exceeded by the Disability Services Council, the Department of Rehabilitative Services, and local government. Almost two-thirds of the survey participants expressed confusion about the role of Disability Services Council or were unaware of the Council's activities. Many Board members indicated that the Council should have a more visible role with the DSBs.

Three-fourths of the survey participants believe that the Department of Rehabilitative Services has been supportive of the DSBs. When questioned about the nature of this relationship, a majority of the respondents described their Board's relationship with the DRS liaison.

When asked whether their DSB received support and assistance from their local government, over two-thirds of the members responded yes. Some examples of the level and type of assistance provided by local governments included furnishing staff support, responding to requests or initiatives of the DSB, and obtaining meeting space and interpreter services.

Approximately three-fourths of the respondents thought the DSBs are meeting their original purpose. A number of comments focused on the Boards' ability to increase public awareness in their localities. A majority of the respondents (74%) stated that the Boards were performing their ADA resource and referral duties by advising local governments and businesses.

When the survey participants were asked if the role or function of the DSBs should be redefined, the responses were almost evenly divided. Forty-nine percent of the members felt that the Boards' role should change, with 51% indicating that no change was needed. When analyzing the responses to this question, the comments expressed by DSB members for a change in their role focused on the need for a further refinement of their responsibilities and authority. These respondents felt that the Boards should be more proactive and several comments focused on the need for additional resources to enable the Boards to accomplish their goals. DSB members who answered that the purpose of the Boards should remain the same indicated that the Boards are doing well and performing a useful role. Generally, the members' comments when responding to this question described issues they have encountered when trying to successfully meet their responsibilities while still working to become established in their localities.

A majority of the members interviewed believe that the DSBs have been able to secure the membership as originally planned and include the most appropriate members. Most respondents felt that the DSB membership is well-rounded, but that attendance is often an issue. A third of the members interviewed stated that their Boards have not been able to appoint all of the members that they need. About a quarter of the respondents believe the DSBs do not include the most appropriate members and expressed the need for a greater number of individuals with disabilities to serve on the Boards.

The survey participants were asked to identify what they believe are the key ingredients for establishing an effective DSB. A variety of responses was given, however, the most frequent response was finding knowledgeable and committed individuals to serve on the Boards. Other responses included obtaining more participation from people with disabilities and ensuring that the Boards have a good cross representation of individuals.

The final survey question asked the DSB members if there were any recommendations they would have for the Disability Commission to further strengthen the role of the DSB in their locality. A range of comments were provided by the respondents, however, only one recommendation was frequently given. Approximately a quarter of the respondents stated that additional funding was needed to assist the Boards in accomplishing their goals. Other comments focused on the need for more staff support, clarification of the Boards' responsibilities, and increase communication with the public about the Boards and among the various parties involved with the Board.

Conclusion

A majority of the members interviewed for this evaluation have served for two years or more and represent individuals with physical and sensory disabilities and family members on their Boards. These survey participants have been actively involved in the initial establishment of the Boards in their localities. Based on these experiences, the respondents were able to provide insights regarding the challenges they have faced, the accomplishments they have made, and the changes required to increase the effectiveness of their local Board.

The telephone survey results do not provide a uniform picture of the DSBs, but rather illustrate the uniqueness of each of the Boards as they have become established in their localities. Despite this variation, many of the Boards have focused their attention toward similar issues, including transportation, accessibility, and conducting and updating their needs assessments. However, a variety of other issues were identified specific to the Board's location in the state.

The DSBs believe that they have been able to meet their responsibilities and have identified increased public awareness in their communities as one of their greatest achievements. Administrative issues identified by a sizable number of respondents included the need for (1) better orientation of Board members, (2) a clearer understanding of the amount and type of assistance which the Department of Rehabilitative Services can provide, and (3) the identification of members who are willing and committed to serve on the Boards.

The survey respondents were divided as to whether the DSB role should be redefined. When analyzing the responses to this question, it appears that the majority of members do not believe that a fundamental redefinition of purpose of DSBs is needed. Rather, members are seeking clarification of their role and their relationship with the Department of Rehabilitative Services. A critical factor which impacts the Board members' perceptions of the support they receive from DRS and the purpose or direction of the Board, is the DRS liaisons and their relationship with the individual Boards. DSB members who believe that their Board received the guidance and support they needed from DRS focused their comments on the work done by their liaison. The DRS liaison plays a key role in providing the Boards information and an understanding of the other players involved, for example, the Disability Services Council and state agencies.

It is apparent from the responses provided by a majority of survey respondents that the DSB members have not been fully informed about the Disability Services Council and their relationship with the Boards. The Board members interviewed are unclear about the DSBs' relationship with Disability Services Council and the amount of support and guidance the Council can provide. In terms of the other parties involved with the DSBs, most of the respondents have found the Department of Rehabilitative Services and local government supportive of their efforts to establish the Boards and implement their activities.

The Boards have been able to implement a range of activities to meet their ADA resource and referral duties. They believe that identifying individuals who are willing and committed to serve on the Board plays a critical role in the success of the Boards. The members expressed a need for additional resources to enable them to achieve their goals and the need for continuing clarification about their role and ongoing communication with agencies, organizations, and groups concerned about the needs of individuals with physical and sensory disabilities.

The telephone survey results provide a picture of the Disability Services Boards still early in their growth and development. Some Boards are further along in their work than others, but despite the challenges the Board members have faced, they believe they are making an impact in their localities to enable individuals with physical and sensory disabilities to more fully participate in their communities.

Evaluation of Funding Initiatives

The Disability Commission established funding priorities that addressed important gaps in the Commonwealth's service delivery system for individuals with physical and sensory disabilities. Specific funding initiatives identified for review by the Evaluation Work Group included the Consumer Services Fund, Rehabilitative Services Incentive Fund, Personal Assistant Services Program, Long-Term Rehabilitation Case Management Program, and Cognitive Rehabilitation Program. For each initiative, program policies and practices, service utilization data, cost information, program effectiveness and consumer satisfaction data were reviewed and summarized. Major evaluation findings for each initiative are summarized below.

Consumer Services Fund

The purpose of the Consumer Services Fund (CSF) is to help individuals with physical or sensory disabilities access services that cannot be funded through existing programs. It is a **"fund of last resort"** for individuals needing to overcome funding or eligibility barriers. Services must be directly related to the individual's disability. Example services include special equipment or supplies, assistive technology, and home and vehicle modifications.

Persons utilizing the Consumer Services Fund must meet all of the following eligibility criteria:

1) Individuals residing in Virginia who have a demonstrated physical or sensory disability. There is no age restriction.

2) Individuals who have exhausted all other potential resources.

3) Individuals for whom the requested item supports one or more of the following outcomes:

   - Enhances self-sufficiency of the individual with a disability by increasing or building on his/her capacity to carry out the full range of personal activities of daily living.

   - Enables unsalaried care-giver to continue as a primary support to an individual with a disability.

   - Prevents placement of an individual into an institutional setting such as a nursing home, hospital, or other facility.

- Achieves or maintains employment by an individual with a disability or an unsalaried care-giver.

Individuals access the Consumer Services Fund through a formal application process. It is required that a human service advocate assist the individual with a disability in completing the application. The Department of Rehabilitative Services has disseminated information about the Fund extensively. Fund guidelines are made available to counselors, case managers, and other direct service staff employed by DRS, DVH, and DDHH. There is a mailing list of over 1,000 individuals and organizations including Employment Service Organizations, Centers for Independent Living, Community Service Boards and Area Agencies on Aging.

Applications for CSF assistance are reviewed by a screening team consisting of interagency representatives and persons with a disability. Applications are evaluated for funding based on established award criteria and the extent to which the requested service(s) would benefit the applicant. There is also a provision in the funding guidelines for emergency access to the Consumer Services Fund in instances where there is an urgent need for services and strong justification that the application could not have been submitted during the most recent review process and cannot wait until the next scheduled solicitation.

Methodology

The DRS program manager for the Consumer Services Fund was interviewed, and participant services and program expenditure data for Fiscal Years 1994 and 1995 were reviewed.

Participants

The DRS program manager for the Consumer Services Fund participated in this evaluation.

Results

Allocation - The 1993 General Assembly allocated $375,000 for the Consumer Services Fund for FY 1994 to be implemented July 1, 1993. $425,000 has been allocated each year for FYs 1995 and 1996.

Expenditures - The full $375,000 allocation for FY 1994 and $425,000 for FY 1995 were reportedly obligated and expended for services and supports for persons with physical or sensory disabilities.

Participation - Table 2-1 summarizes participation levels for the Consumer Services Fund in FY 1994 and FY 1995:

Table 2-1
Consumer Services Fund Applications

Consumer Services Fund Applicant and Participant Status	FY 1994	FY 1995
Total Applications Received	187	185
# of Applications Funded	91	90
# of Applications Not Approved for Funding	78	80
# of Applications Conditionally Approved for Funding If Other Payment Resource Cannot Be Found**	18	15

** In both FYS 1994 and 1995, alternative resources were located to acquire the items and services referenced in the conditionally approved applications. Funds from the Consumer Services Funds were not used.

Review of Applications Not Approved for Funding - A review of applications for CSF funds that were not approved revealed that applications are not funded for a variety of valid reasons. In some instances, the review team identifies potential alternative funding resources, and feedback is given to applicants regarding possible other means of addressing the identified need. For example, Rodney, a 33 year old male with a spinal cord injury requested funding to pay for attendant care for 40 hours per week. Until now, he had been paying an attendant for less than 40 hours and his mother provided primary care services. His mother, however, has severe heart problems, so Rodney requested funding for additional services to enable him to remain at home until his mother recovered, rather than move to a nursing home. The review team referred Rodney's case to the Personal Assistance Services program and initiated contact on his behalf.

Some applications are potentially appropriate for funding, but the funding requests exceed the funds available in the Consumer Service Fund. Funding in those instance is done on a priority basis to those applications that appear to have the most critical needs that can be addressed with available funds. Orrick, a 43 year old amputee with spina bifida, requested assistance to purchase a vehicle modified with a wheelchair lift and hand controls. Orrick, however, resides in Norfolk and does have access to public transportation. The review team determined that, given limited funds, the priority must be placed on those without any public or private transportation.

Some applications are inappropriate for CSF funding because they do not meet the stipulation for a one-time or short-term need. Betty requested funding for respite care on Saturdays for her daughter, Christina, who has cerebral palsy and severe mental retardation. Christina's parents both work Saturdays and are facing the possibility of having to place her in a nursing home, as they cannot afford for either to quit their jobs. While the review team recognized the need here, the request was for long-term funding and therefore inappropriate for the CSF.

Other applications are inappropriate for CSF funding because they do not address disability-specific needs only. Sharon, a 38 year old female with manic-depressive disorder, rheumatoid arthritis, and diabetes type II, submitted a request for funding to update and repair her home; for example, she stated the windows and doors need replacing and the plumbing needs repair. The review panel determined that the request was inappropriate for CSF funding because it felt home renovations do not meet the requirement of the guidelines.

The Consumer Services Fund is serving a predominantly adult population. In FY 1995, 65.6% of the funded applications were for individuals in the age range of 26-55. 4.4% and 15.6% were in the 19-25 and over 55 age ranges respectively. The remaining 14.4% were for persons under the age of 19.

The fund is having a statewide impact. In Fiscal Year 1994, approximately 33% of the fund participants resided in the southwest region of Virginia, the area of the state usually considered to be most limited in service and support resources for persons with a disability. The place of residence for fund participants in FY 1994 is as follows:

Southwest Region:33%
Tidewater Region:18%
Northern Region:22%
Central Region:25%

The Consumer Services Fund is serving individuals with a wide range of primary physical or sensory disability. Table 2-2 presents the primary disability of funded applicants for FYs 1994 and 1995.

Table 2-2
Primary Disability of Consumer Services Fund Applicants
(Funded Applicants Only)

Primary Disability	FY 1994	FY 1995
Spinal Cord	12	10
Hearing Impaired	7	6
Visually Impaired	7	17
Arthritis	3	11
Polio	4	3
Amputee	7	5
Diabetes	5	4
Muscular Dystrophy	2	3
Cerebral Palsy	18	3
Multiple Sclerosis	4	4
Traumatic Brain Injury	8	2
Other	14	22
Total	91	90

Services Provided through the Consumer Services Fund - The Consumer Service Fund is utilized by participants to secure a variety of services. The mean cost per service for participants is approximately $4,700. Expenditures per service range from $200 to approximately $20,000. Vehicle/conversions and home modifications are the higher cost services. Vehicle/conversions are the most frequently utilized service for both years, constituting 28.6% of the purchased services in FY 1994 and 33.3% in FY 1995. Table 2-3 summarizes the utilization of services through the Consumer Services Fund.

Examples of Consumer Services Fund Participants and Services - The following case descriptions are for individuals who received services through the Consumer Service Fund and are representative examples of the people being served and benefits being realized.

Table 2-3
Service Utilization

Service Purchased through Consumer Services Fund	FY 1994	FY 1995
Vehicle/Conversions	26	30
Housing Support	3	3
Prosthesis/Braces	6	11
Home Modification	8	6
Medical Services	7	6
Hearing and Visual Aids	8	4
Wheelchair	9	3
Assistive Tech/Computer	7	6
Crisis Therapy	3	1
Others	9	20
Companion Services	5	0

Example #1 - Scott, 4 years old, has cerebral palsy and uses a power wheelchair for all his mobility. His family's home does not have an accessible bathroom; hence his parents must lift him in and out of the bathroom. He needs access to the bathroom to enhance his independent functioning as he matures. Scott receives SSI and his family's income is very low. Since the family was not able to afford the home modifications, his parents solicited all community agencies, including twenty churches, which resulted in a contribution of $300. Because the request met the "fund of last resort" requirement and it was deemed critically necessary, the Consumer Service Fund funded the remaining costs of the bathroom modifications ($3,851). Scott and his family now benefit from his ability to be more independent.

Example #2 - Mary, 68, is retired on Social Security and has residual effects from a stroke and congestive heart failure. She lives with her daughter and is dependent on her physically for personal assistance. Mary's daughter also has a heart condition that restricts her ability to provide her mother the necessary physical assistance needed for her to remain living at home. To achieve greater independence in her activities of daily living and enable her to maintain her present living arrangement, Mary needed a shower bench ($42) and a lift chair

($520). As these items were not deemed medically necessary, they could not be funded through any other resource. The Consumer Services Fund filled this funding gap by purchasing both items, hence allowing Mary to remain in the home.

Example #3 - Andy, 40, recently completed a Masters degree in mechanical engineering and was subsequently offered a job as a ballistics engineer. However, the job was located 130 miles away in a rural area without public transportation. Having lived in an urban area, Andy, who is quadriplegic, had access to wheelchair accessible public transportation to attend college. It was imperative that he have a vehicle in order to accept his new job. No funding source exists in Virginia that assists individuals with disabilities to purchase vehicles. The Consumer Services Fund provided $7,500 to purchase a used van. Andy was also a client of the Department of Rehabilitative Services, and he received financial assistance from DRS in moving to the new community and locating accessible housing. DRS paid for conversion of the van with a wheelchair lift and hand controls. Andy is highly successful in his new job. This job will potentially allow Andy to terminate from SSDI.

The Consumer Services Fund is clearly the "last resort" for people with disabilities and their families with critical needs that are not met through existing programs. Zoe, for example, is an infant with multiple disabilities, including a brain stem malformation which makes her extremely prone to apnea. She needs an apnea monitor, which she had through her parents' medical insurance until the insurance company reached its spending cap. Several infant monitor alarms have indicated that Zoe is at high risk to sudden infant death syndrome (SIDS) without the monitor. The insurance company will pay for up to 80% of their price cap for purchase of a monitor. The monitor costs more than the allowed cap and needs to be serviced and re-equipped with leads, electrodes, and other supplies. Service and supplies are not covered by the insurance. Zoe's parents requested funding for the portion of the purchase price of the apnea monitor not covered by their insurance and for service and supplies for one year. Without the monies provided by the CSF, Zoe's parents felt they would have had to institutionalize her until the monitor was no longer needed.

The fund also enables people to maintain their independence and productivity. Jeffrey is a 24 year old male diagnosed with acid maltase deficiency in late 1989. The therapy for this rare disease is a high protein diet and a daily exercise program. Jeffrey works for a computer company and maintains a household, but by 1993 his condition had deteriorated to where his weight was 52% of his ideal body weight. He cannot swallow the necessary amounts of protein and requires supplemental enteral feedings to provide the extra protein. Jeffrey requested funding for the supplemental enteral feedings for one year, after which he expects to be eligible for Medicare, which would contribute to the payment of these services. The CSF funded the needed assistance for a six month time period as allowed by fund guidelines. With that assistance, Jeffrey could maintain employment and his home. CSF representatives have also worked with Jeffrey to help assure transition to Medicare funding without interruption of the needed service.

Evaluation Summary - The guidelines established for the Consumer Services Fund are responsive to its intended purpose. There seems to be an appropriate level of awareness of the fund among persons with a disability and their advocates in Virginia. Approximately 190 applications per year are being received for funding. The application review process is effectively screening applications for need. The allocation to the Consumer Services Fund is fully utilized to provide a wide array of services to a population representative of persons with physical and sensory disabilities.

Overall conclusions from this evaluation are:

1. **The Consumer Services Fund is effectively managed and appears to be fulfilling its intended purpose as a "fund of last resort" for individuals with a physical or sensory disability.** Approximately 180 individuals with physical or sensory disabilities have received services through the CSF since its initiation at the start of FY 1994.

2. **Because of the short term nature of service intervention through the Consumer Services Fund, it is difficult to evaluate the longer term impact of these services.** Funded services do appear to be addressing situations where there is a need for "extraordinary services beyond the scope/capacity of local service agencies" as called for in the fund guidelines.

3. **Information is not available regarding the specific number of unfunded applications that met funding criteria but were turned down by the CSF screening committee because of lack of funds.** Without this information, it is difficult to establish the extent of the unmet need for the assistance provided through the Consumer Services Fund. Unfunded applications to date should be further reviewed to determine the number of these applications that fall into the unmet need category.

Rehabilitative Services Incentive Fund

The purpose of the Rehabilitative Services Incentive Fund (RSIF) is to support local investment in community programs and services for persons with physical and sensory disabilities. The RSIF assists Disability Services Boards (DSBs) create services and programs designed to meet local needs of this population. The RSIF provides the opportunity for localities to collaborate with private organizations and state and local agencies, draw down state funding, enhance existing services or create new programs to meet local needs.

Methodology

The DRS program manager for the Rehabilitative Services Incentive Fund was interviewed. Published guidelines for the program and applications submitted by DSBs in response to these guidelines were reviewed. Data on RSIF allocation and match requirements for each DSB were compared with application and award data available as of August, 1995.

Participants

The DRS program manager for the Rehabilitative Services Incentive Fund participated in this evaluation.

Results

Allocation - The 1994 General Assemble awarded $500,000 to the RSIF for FY 1996 with funds to be available July 1, 1995. Funds are allocated to DSBs on a formula basis and must be matched with local funds. The allocation formula combines the following information to estimate level of need in each DSB area:

1) Census data,
2) Number of individuals served by disability agencies (DRS, DVH, DDHH),
3) Number of students receiving special education services as defined by the Department of Education, and
4) Number of people receiving disability benefits from the Social Security Administration.

The minimum allocation for a DSB is $1,000.

Expenditures - At the time of this study , DRS is in the process of awarding RSIF funds based on applications from DSBs. As of October 1, 1995, $430,798 of the FY 1996 allocation has been awarded to DSBs.

Participation - The Disability Services Commission approved November 4, 1994 allocation levels of RSIF funds to each DSB. Fund allocations ranged from the $1,000 minimum for DSBs such as Richmond County, Lancaster, and Bath/Highland to a high of $71,510 for the South Hampton Roads DSB. Of the 44 DSBs in Virginia, 38 (86.6%) have submitted applications to date to the RSIF. A breakout of DSB participation in the application process is as follows:

a) Six DSBs did not submit applications in response to the FY 1996 application process for the RSIF. The DSBs not responding to data to the FY 1996 application process are Brunswick County, Lancaster County, Northumberland County, Richmond County, Staunton City, and Westmoreland County. The total RSIF allocation for these 6 DSBs is $9,330. Information is not available on why applications were not received from these DSBs.

b) Applications for $490,670 were received from the remaining 38 DSBs. The Lenowisco and Mount Rogers DSBs joined together to submit a combined application. The remaining 36 DSBs submitted applications individually. The application from the Western Piedmont DSB was not approved by the RSIF Review Panel because that DSB did not provide the required matching funds.

c) The remaining 37 DSBs were awarded a total of $430,798 to initiate RSIF projects. The DSBs provided approximately $283,000 in match funds to secure these grants.

d) As of October 1, 1995, $69,202 of the FY 1996 RSIF appropriation have not been awarded. On September 27, 1995, the Disability Services Commission amended the Guidelines for Establishment and Operation of the State Rehabilitative Incentive Fund to provide operational guidance on the award of the $69,202 to the DSBs. DRS will develop an Request for Proposal that will list the amount of funds available to DSBs and will solicit proposals. Priority in awards will go to the DSBs who have not yet accessed any of the RSIF funds allocated for them. Proposals from these DSBs will be reviewed first. Awards for the remaining funds will be based on a published proposal rating system. A cap was established of $10,000 per proposal.

Review of Findings - The guidelines for the RSIF, the allocation formula and match requirements, and application solicitation and review/approval process all appear consistent with the legislated purpose of the Rehabilitative Services Incentive Fund. The initial applications for FY 1996 propose to develop services and supports that will address the local needs of persons with physical and sensory disabilities. More than 50 separate proposals were submitted (many DSBs submitted multiple proposals). A sample of the planned services and supports contained in the FY 1996 applications are:

Transportation:

- paratransit automated reservation and information system
- medical transportation for persons with a disability

Community Access

- purchase of assistive technology for local public library
- county disability awareness day and portable wheelchair access ramp
- enhancement of a region's interpreter services
- development of a deaf resource center
- establish a computerized 800-number accessible information and referral system

Services to Individuals and the Community to Encourage Community Integration

- accessibility modifications to multifamily properties
- establishment of a satellite independent living clinic
- first year housing coordinator position to make possible a group living arrangement for severely disabled young adults
- pilot employment workshop program for people with disabilities
- increasing opportunities for recreation for persons with physical and sensory disabilities
- home delivered meal program for persons with a disability

The proposals were reviewed first by a panel representing persons with physical and sensory disabilities as well as several agencies involved in the delivery of services to this population. The panel made recommendations regarding funding to the Disability Services Council. The DSC met on June 15, 1995 and conducted a final review of proposals. DRS is currently working through the process to award funds to approved proposals and also to secure additional applications to utilize uncommitted RSIF monies.

Evaluation Summary: Evaluation of the impact to date of the RSIF in not possible because this program is currently in the process of completing the initial fund awards. All implementation activities to date are supportive of the RSIF achieving its purpose. It is important to note that the $500,000 RSIF appropriation leverages additional funds and support at the local level through the match process. For FY 1996, the first year of RSIF funding, that match total will be over $300,000. Future evaluations of the RSIF should consider the following points:

1. **In a number of instances, the RSIF DSB allocations and award levels involve small amounts of funds.** Consideration is needed as to whether the $1,000 minimum allotment for a DSB establishes a critical mass of funds to allow for a significant impact on rehabilitation services in a community. The funding formula established for this program does appear balanced in terms of allotting funds to mid- to large- size communities. Particular evaluation attention is needed to the impact of the RSIF in small communities, which frequently have

limited resources and cover large geographic areas. Options for consideration include raising the minimum allotment or setting aside funds for a limited number of high priority projects which have funding requirements beyond the allotted funds for a specific DSB.

2. **The RSIF is consistent with current DRS efforts to decentralize services and to support community service development.** Future evaluations of this program should emphasize measurement of the actual impact achieved by funded projects and the ability of communities to maintain and to further develop initiatives generated with RSIF support. There is a very positive history in Virginia of establishment grant funding systematically improving over time the availability and quality of services. The grant funding strategy worked effectively in Project Unite, the Virginia Assistive Technology System, and the 5 year statewide supported employment systems development project.

Personal Assistance Program

The Personal Assistance Services (PAS) initiated through the Disability Commission is managed by the Department of Rehabilitative Services (DRS). The PAS program provides help with daily living activities for people with severe physical disabilities. PAS recipients select, schedule, and manage the services independently. This permits a level of flexibility and choice that encourages greater independence and productivity. PAS is available in all areas of the state to a limited number of qualifying consumers of all ages. Recipients must meet financial criteria, but may share in the cost of services based on individual circumstances.

Evaluation Methodology

Evaluation information was provided by DRS staff working with the Personal Assistance Program. Information on utilization was provided by DRS staff. In addition, several studies have been conducted by DRS over the past 12 months. These studies include: 1) a collaborative effort between the National Rehabilitation Hospital Research Center and DRS to evaluate and compare the outcomes of individuals receiving PAS with similar groups of individuals not receiving these services; 2) a survey conducted by DRS of the 10 Independent Living Centers and the state operated Independent Living Program at Woodrow Wilson Rehabilitation Center to obtain information in such areas as the number of consumers participating in the Assistant Management Training, number of consumers who applied for PAS services, and characteristics of participants and personal assistants providing services; and 3) a study conducted by DRS to obtain detailed information about the personal assistants participating in the DRS program. All of the information collected through these studies was done by mailed surveys.

Participants

The participants in the studies are PAS participants, individuals who are on a waiting list to receive these services, and individuals who are paid personal assistants.

Results

The Personal Assistance Services program served 105 individuals with disabilities during Fiscal Year 1995. There are 300 individuals who are on a waiting list to receive services. Persons on the waiting list meet program admission criteria, but are not receiving services because of a lack of sufficient program fiscal resources to meet the identified need.

Program Funding - The PAS program operated by the Department of Rehabilitative Services was originally established through grant funds provided by the Virginia Board for People with Disabilities. Since 1993, when grant funding ended, the program has been primarily funded by state general funds, allocated to the Department for the PAS Program by the General Assembly. Fiscal Year 1995 appropriations for the program totaled $739,000, an increase of $189,000 from Fiscal Year 1994. Most recent available information indicates that the average annual cost of PAS services is $5,580 per individual.

Recent funding increases have resulted from a transfer of funds from the Department of Medical Assistance Services, reflecting a policy which appears to value the delivery of personal assistance services as a mechanism through which to reduce more costly nursing facility placement. Additional state funds were transferred from DMAS in the amount of $329,472 to the DRS PAS program, effective in Fiscal Year 1996.

An additional source of funds for PAS services in Title I of the Rehabilitation Act. Title I monies are primarily federal funds which require a state match on an 80%/20% federal/state match ratio. These funds are used to support vocational services to DRS clients and may be used to provide PAS services to individuals when it is determined that the services are necessary to promote the individual's employment. In April, 1995 DRS modified their internal policies so that all PAS services, including those provided through the Title I programs, were coordinated through the central PAS office.

Impact of PAS Services on Recipients - Results from the study conducted by the National Rehabilitation Hospital Research Center are based on surveys completed by 124 individuals with disabilities. Half of these individuals are consumers participating in the PAS program. The remaining individuals are persons who have been determined eligible for the program and are presently awaiting services. Individuals participating in the PAS program rated their disability as severe more often than those individuals on the waiting list. A greater number of DRS Personal Assistance Services program participants indicated the existence of a disability or health condition other than their primary disability. The primary disability of consumers of the 62 individuals presently receiving services is identified in Table 2-4.

Table 2-4
Primary Disability Most Frequently Reported by PAS Consumers
N = 62

DISABILITY	PERCENT
SPINAL CORD INJURY	32
CEREBRAL PALSY	19
MUSCULAR DYSTROPHY	15
MULTIPLE SCLEROSIS	15

Individuals receiving PAS services through the DRS program receive an average of 38 hours of paid personal assistance a week. This figure is more than three times the number of hours received by individuals waiting for services, who may receive services through other paid or unpaid sources. Individuals on the waiting list receive twice as many hours of weekly unpaid assistance from their family and friends than do their PAS counterparts. When these individuals do receive paid personal assistance services, a substantially higher percentage of their personal funds are used to cover these costs.

PAS participants are employed at twice the rate of those on the waiting list, despite the finding that PAS recipients appeared to possess more severe disabilities. They spend more days out of the house per week and utilize preventive health care services more often than their waiting list counterparts. In addition, they express significantly higher amounts of control over such areas as recreational activities, sharing feelings, and romantic relationships than individuals on the waiting list.

Individuals participating in the PAS program are able to receive a course on Assistant Management Training. This training is conducted through the Independent Living Centers across the state. More participants receive the training on an individual basis at the Centers. Approximately a third of the participants receive training in their homes, with another third attending a group training at the Centers. A significant number of training activities are conducted by individuals with disabilities, approximately 40% of whom are PAS consumers. Table 4-5 identifies the major providers of personal assistant management training.

Table 2-5
Providers of Personal Assistant Management Training

PROVIDER	PERCENT
INDIVIDUAL WITH A DISABILITY NOT A PAS CONSUMER	42
STAFF, PAS CONSUMER	21
VOLUNTEER, PAS CONSUMER	21
VOLUNTEER, INDIVIDUAL WITHOUT A DISABILITY	11
STAFF, INDIVIDUAL WITHOUT A DISABILITY	5

The survey of personal assistants conducted by DRS found that almost half of the respondents were receiving food stamps, with the remaining number receiving other forms of assistance such as SSI/SSDI, housing subsidies, AFDC, and fuel assistance. When asked if their need for public assistance decreased after becoming a personal assistant, a majority responded yes. Over a quarter of the assistants have CPR training or have a certificate as a nursing attendant. Other certificates held by personal assistants include licensed practical nurse and emergency first aid.

Satisfaction with PAS Services

A majority of the survey participants (69%) train their own personal assistants. Consumers also assume responsibility for instructing and directing their assistants. In some instances, spouses, parents and siblings may also be involved in the managing the activities of the assistants. A total of 87% of all consumers indicated that they were very satisfied or extremely satisfied with their control over the choice of their assistant. They were also generally satisfied with their involvement in deciding the number of hours of help that they needed.

Consumers expressed satisfaction with the cost of assistance and with the amount of funds provided to pay for the number of hours they need. The consumers reported that the assistants are dependable and thoughtful with the assistance they provide. PAS participants are highly satisfied with the safety of the assistance provided and are very satisfied with their relationship with their personal assistants. Table 2-6 summarizes consumers' level of satisfaction with the dependability of PAS providers.

Table 2-6
Consumer Satisfaction with PAS Providers' Dependability
N = 62

DEGREE OF SATISFACTION	PERCENT
SLIGHTLY SATISFIED	5
SOMEWHAT SATISFIED	16
VERY SATISFIED	31
EXTREMELY SATISFIED	45

Results of the survey also indicate that respondents are less than fully satisfied with the availability of individuals willing and able to serve as personal assistants. For over half of the consumers, their ability to obtain an assistant regardless of the time or day was a source of relative dissatisfaction. These areas remain a challenge as consumers work to create their own schedule for receiving assistance, enabling them to fully participate in their communities.

Summary

The consumers who participate in the DRS Personal Assistance Services program have significant disabilities and are more likely to have a health condition or existence of a disability other than their primary disability. These participants receive more paid hours of care than those individuals on the PAS waiting list and do not spend a significant portion of their personal funds to receive these services. Because those on the waiting list spend a substantially higher percentage of their own funds on personal assistance, the data suggest that the PAS program helps reduce a significant financial burden on the consumer, as well as provide support to unpaid family caregivers. In conclusion:

1. **The PAS program has a dramatic impact on the independence and productivity of participants.** PAS participants are more likely to use preventive health care services and spend more time during the week outside of their homes. PAS recipients are employed at twice the rate of those on the waiting list, despite the finding that PAS participants appear to have more severe disabilities.

2. **The PAS program also has a very positive impact on personal assistants.** Personal assistants report less of a need for public assistance through such programs as food stamps, AFDC, or fuel assistance after being hired by PAS consumers.

3. **While available to individuals in all areas of the state, the PAS program is only meeting a small percentage of the identified need.** Presently, 300 individuals who meet program admission criteria are presently awaiting services.

Long Term Rehabilitation Case Management Program

The purpose of the Department of Rehabilitative Services (DRS) Long Term Rehabilitative Case Management Program (LTRCM) is to provide case management services to individuals with physical and sensory disabilities, and their families. Individuals are considered eligible for the LTRCM Program if they have a physical or sensory disability, require a special combination of services for a lifelong or extended duration, or their disability results in substantial limitations in three or more of the following life areas:

- Self-care
- Learning
- Self-direction
- Language
- Mobility
- Independent Living
- Economic Sufficiency

The Long Term Rehabilitative Case Management Program began in November, 1989. It is staffed by a program director, 5 full time case mangers and 1 hourly case manager position (State P-14 position). The case managers assist individuals and their families develop strategies to match their rehabilitative needs with appropriate service providing agencies, organizations and individuals, both private and public. Case managers access and coordinate services in the following areas:

- Medical Treatment
- Job Training and Placement
- Individual and Family Counseling
- Independent Living Services
- Financial and Legal Support
- Housing
- Support Groups
- Transportation
- Education

Methodology

The DRS program director for the Long Term Rehabilitative Case Management Program was interviewed, and participant services and program expenditure data for Fiscal Years 1994 and 1995 were reviewed. Also, The June, 1994 report of the LTRCM Program Satisfaction Survey and the April, 1994 report on the Service Linkage Study were reviewed.

Participants

The DRS program manager for the Long Term Rehabilitative Case Management Program participated in this evaluation.

Results

Allocation - The annual allocation for this program is $294,988.

Expenditures - Approximately $235,000 per year is expended on staff salaries for the program director and the 6 case manager positions. Approximately $20,000 to $30,000 per year is used as an emergency service fund to acquire services for individuals receiving case management services. The emergency service fund is utilized in situations where alternative funding sources cannot be identified and the service(s) is critical to the individuals rehabilitation program. The remaining funds are reportedly expended on staff support costs such as travel and related costs.

Participation - As of the end of FY 1995, the LTRCM Program had approximately 155 active participants. 22 of these individuals entered the program in FY 1995. As of August, 1995, there were 58 persons on the waiting list for LTRCM services.

More detailed information is available regarding program participants in FY 1994. Of the 140 individuals in the program year end, FY 1994, the most frequent primary disabilities were traumatic brian injury (43.6%), spinal cord injury (25.0%), and brain injury (12.1%). 74.3% of the participants were males, and approximately 65% were between the ages of 50 - 69. Less than 1% of the participants were under the age of 30. Approximately 51% lived with parents or other family members, and 20% lived independently or with spouse or children.

LTRCM Services Received by Participants - Staff of the Long Term Rehabilitative Case Management Program provide services in each of the 4 DRS regions in Virginia. The program assists participants through access and coordination of a wide range of services. Table 2-7 identifies the services most frequently explored, planned or implemented for LTRCM participants in FY 1994.

Table 2-7
Types of Services

Service	Frequency
Assistive Technology	6.6%
Employment and Training	15.8%
Client Support	4.9%
Education	3.9%
Family Support	3.7%
Medical Rehabilitation	15.2%
Personal Assistance Services	6.0%
Residential/Housing	11.7%
Transportation	5.4%

The remaining services included but were not limited to socialization, recreation/leisure, home health, and behavioral training.

Example of LTRCM Services - The 51 year old male was referred to the Long Term Rehabilitation Case Management Program via a nurse case manager of a private rehabilitation provider in November, 1991. In September, 1990, the consumer sustained an incomplete spinal cord injury, traumatic brain injury with mild deafness, and loss of bladder control following a work injury for which he received assistance through worker's compensation. He regained his ability to walk during 5 months of rehabilitation, but he was left with chronic lower back pain and a neurogenic bladder requiring self-catheterization four times daily.

The consumer was taken into active management services through the LTRCM Program in October, 1993. At that time, he lived in a small wooden house in a rural area of Virginia where he had resided for the past eight years with his adult daughter and eight year old granddaughter. The LTRCM Program provided case coordination to obtain the services needed to address the consumer's fragile medical condition and to allow the individual to remain in his home, thereby avoiding costly residential health care. At the point of initiation of LTRCM services, he had not seen a physician for six months, due to a lack of transportation despite his eligibility for Medical Insurance benefits. Arrangements were made for a home health technician to visit monthly to check the quality of his self-administered bladder care.

Case management services were provided in securing safe and accessible housing through FHA financing. A hearing evaluation was provided and telephone amplification was secured. Evaluations and services were secured from the Woodrow Wilson Rehabilitation Center and Independent Living Center. Arrangements were made for the consumer to attend the county literacy program. The LTRCM program was able to secure free services in many instances, such as the hearing evaluation and telephone amplification, and other instances helped arrange for one time expenditures that helped the consumer live in the community. The LTRCM Program provided critical and cost effective service coordination that helped the consumer avoid the costly alternative of long-term placement in a nursing facility as a result of poor medical care.

Evaluation Summary - The Long Term Rehabilitative Case Management Program has been in place since 1989. Two separate studies sere completed in FY 1994 involving LTRCM participants. The first, a telephone interview study of participant satisfaction indicated that approximately 78% of persons surveyed reported being completely satisfied with the services received. The results of this survey indicated that LTRCM participants were satisfied with the coordination services they received and believed that these services had improved their rehabilitation situation. The second study compared active LTRCM participants and individuals on the program's waiting list to determine whether individuals receiving LTRCM services were linked to more service resources than individuals on the waiting list. Results of this study indicated that LTRCM participants were linked to an average of 4 more service resource (13.9 compared to 9.3) than individuals on the waiting list.

Evaluation conclusions are as follows:

1. **The Long Term Case Management Program is assisting approximately 140 persons with physical disabilities access a wide array of community based rehabilitation services.** There are positive indications that the LTRCM Program is providing services in a manner satisfactory to service recipients. The LTRCM is effectively fulfilling its purpose with those individuals who are being served.

2. **Recent program data indicate that the LTRCM Program is able to assist approximately 20-25 new participants per year.** Because of the long term support needs of program participants, there is a limited capacity at current staffing levels to serve new participants. The current waiting list of 58 persons for services is an indication of the need for the services provided through this program. Consideration is needed for alternatives, including possible expansion of the capacity of the LTRCM Program, to address the unmet need.

Cognitive Rehabilitation Program

The purpose of the Department of Rehabilitative Services (DRS) Cognitive Rehabilitation Program (CRP) is to demonstrate the effectiveness of cognitive rehabilitation services in assisting individuals with an acquired brain injury to achieve greater community integration, live in a less restrictive environment and move forward in their rehabilitation process. Cognitive rehabilitation is the systematic application, by a qualified practitioner, of remedial intervention techniques aimed at improving cognitive processing and the ability to perform daily life tasks.

The CRP serves approximately 6-8 individuals per year with each participant receiving an average of six months of service. The CRP advisory and selection committee prioritizes candidates who are (1) currently residing in an institutional setting such as a nursing home or are at risk of placement in an institutional setting and (b) most likely to benefit from cognitive rehabilitation services in terms of community integration, less restrictive living environments, and progress in their rehabilitation program. The Cognitive Rehabilitation Program represents a "last resort" resource for individuals who need additional intensive support and therapy. The program is targeted to persons who are not eligible for cognitive rehabilitation services under the state rehabilitation program.

Methodology

The DRS program manager for the Cognitive Rehabilitation Program was interviewed, and participant services and program expenditure data for Fiscal Years 1994 and 1995 were reviewed. Also, the 1995 external evaluation report for the CRP was reviewed. This report, titled "DRS Cognitive Rehabilitation Pilot Project: A Program Evaluation", was prepared by J.D. Ball, Ph. D., and Dawn Schlegel, Psy. D., from the Eastern Virginia Medical School.

Participants

The DRS program manager for the Cognitive Rehabilitation Program participated in this evaluation.

Results

Allocation - The 1993 General Assembly allocated $200,000 for the Cognitive Rehabilitation Program for FY 1994 to be implemented July 1, 1993. An additional $200,000 was allocated for FY 1995.

Expenditures - Due to start-up time, services to CRP participants for FY 1994 began in November, 1993. A total of $110,075 were expended in FY 1994. For FY 1995, $234,347 were expended. The FY 1995 expenditure included services carried over from FY 1994.

Participation - Table 2-8 summarizes participation levels for the CRP over the past two fiscal years.

Table 2-8
Number of Participants

CRP Participant Status	**FY 1994**	**FY 1995**
No. Entering CRP	6	8
No. Completing CRP	5	3
No. in Evaluation		1
No. Still Active in CRP		3
No. Terminating Prior to Completion of CRP**	1	1

** The terminations were due to medical problems for the individual in FY 1994 and psychiatric problems for the individual in FY 1995.

CRP Services Received by Participants - The cognitive rehabilitation services received by CRP participants involve the systematic retraining of specific impaired skills, as well as teaching strategies to compensate for functional deficits. Specific services included in a comprehensive programs of cognitive rehabilitation are:

- physical, occupational, speech/language, and recreational therapies
- retraining of attention/concentration and memory
- training in compensation techniques such as use of schedules, electronic devices and organizing
- executive functions such as planning, organizing, self-monitoring
- community living skills instruction

In FY 1994, 3 of the CRP participants received cognitive retraining in a residential setting and 3 received these services on an outpatient basis. For FY 1995, 6 individuals received services in a residential setting, 1 on an outpatient basis, and 1 received home based services.

Examples of CRP Participants and Services - The following case description from a participant in the DRS Cognitive Rehabilitation Program is a representative example of the individuals being served and benefits being realized.

> DJ is a male, age 29, and 9 years post injury. He was a resident of a state psychiatric hospital for 2 years due to behavioral outbursts. He received sis months of cognitive rehabilitation services through CRP. He currently resides in a supervised apartment, is working part-time, and he participates in appropriate social activities in the community. He continues to receive intensive case management and residential supervision.

Review of Findings - The 1995 CRP evaluation study completed by staff of Eastern Virginia Medical College reviewed FY 1994 participant outcomes for the 5 individuals who completed the program. The evaluation report states the following:

> "On the whole, the pilot cognitive rehabilitation project appears to have benefitted most participants in the ways it initially envisioned, at least to some degree. All of the five Participants who completed services were grateful and reported what they perceived to be gains in their paths toward greater independence and vocational readiness. Service providers, DRS case managers, and an independent neuropsychologist were also generally positive". (pp. 59-60)

The evaluation report made recommendations for improving the CRP in the areas of participant screening, premature separations, proposal/delivery of unnecessary services, and aftercare. The CRP Screening and Advisory Committee has responded appropriately to these recommendations. To improve the screening and service delivery process, the Committee is giving more attention to recommending the addition or deletion of specific services for each individual's program as compared to the use of a standard comprehensive program of cognitive rehabilitation that may have included unnecessary or inappropriate services. Services are being monitored more closely through written reports and site visits, and individual needs are being continually reassessed. To minimize premature separations, the Committee is placing a stronger emphasis on assessing medical and emotional problems which might preclude an individual from successfully completing the program. More attention is also being paid to family dynamics and support, and closer scrutiny is being given to monitoring progress. In terms of aftercare services, there is an acknowledged lack of residential options in Virginia for individuals with an acquired brain injury. The CRP Committee continues to advocate for the development of appropriate aftercare services. The actual development of the these services is beyond the scope of the CRP.

Evaluation Summary - The Cognitive Rehabilitation Program is providing cognitive rehabilitation services to individuals consistent with the targeted population and program purpose. On balance, the response to the program by service recipients, service providers, and other participants is positive. CRP representatives have taken appropriate steps to strengthen the program based on the formal evaluation of the first year (FY 1994) outcomes. It is important to note the following reference in the evaluation report for FY 1994 from Drs. Ball and Schlegel:

> "There are many areas in which services might have been delivered more efficiently, and some gains for those participants may have had more to do with interagency communication and cooperation and with concerted attention to someone's needs than with specifics of cognitive rehabilitation services. Nonetheless, in each instance there is now some diminished risk of institutionalization, greater vocational readiness, further community integration, and an enhanced recovery from TBI. DRS case managers and private service providers proved themselves able to work together productively, sometimes in a particularly creative and exciting fashion." (p. 60)

FY 1995 participant outcomes appear consistent with this evaluation of FY 1994 results. The Cognitive Rehabilitation Program does appear to be achieving its purpose of assisting individuals with an acquired brain injury achieve greater community integration, live in a less restrictive environment and move forward in their rehabilitation process. It is difficult, however, to factor out specifically and evaluate the concrete impact of the cognitive rehabilitation services on the progress achieved by participants. It is not possible to make with confidence a recommendation regarding expansion or continuation of the CRP for two reasons:

1. Funds for this program are used to purchase cognitive rehabilitation services. **There is not sufficient information available to measure the true contribution these specific services are making to improvements in the quality of life of program participants.**

2. **The annual appropriation for the CRP program is $200,000, and services are provided to 6-8 individuals.** Costs per participant are in the range of $25,000 to $30,000. Sufficient data is not available to determine the cost/benefit to this program because of (a) the difficulty referenced above in determining the extent to which cognitive rehabilitation services are contributing to participant outcomes and (b) the general, qualitative nature of these outcomes, such as greater vocational readiness and enhanced recovery from TBI.

Evaluation of the Accomplishments and Effectiveness of State-Level Interagency Committees

The Disability Commission, in its 1992 report, stated that "there are few incentives for agencies to work together to serve people with physical and sensory disabilities." Contained in the section, **Interagency Cooperation**, was the identification of the barriers to effective interagency coordination as well as recommendations to address issues and eliminate those barriers. The current evaluation of the status of the Disability Commission's activities included a requirement for the assessment of the impact of the recommendations on interagency activities in comparison with information compiled in 1991 through the Plan of Cooperation. The analysis that was planned was to examine interagency activities that have continued and determine whether or not these activities have expanded. The evaluation was to determine if any patterns, themes, or trends emerge.

Methodology

The Secretary of Health and Human Resources, in a memo dated October 17, 1995, requested a description from each state agency of the interagency work groups, committees, councils or task forces that are directly responsible for the planning or coordination of services for individuals with physical or sensory disabilities. Accompanying the memo, was a list of the interagency groups that were thought to be in existence at the time of the evaluation.

Staff reviewed the information submitted by the state agencies, matched descriptions with the groups known and attempted to classify whether activities of the new committees/councils identified met the intent of the directive from HJR 83.

Participants

The Disability Commission identified the following agencies and their local counterparts as responsible for providing, funding or regulating these and other services needed by people with physical disabilities or sensory impairments: Department for the Deaf and Hard of Hearing, Department of Rehabilitative Services, Department for the Visually Handicapped, Department for the Aging, Department of Education, Department of Health, Department of Housing and Community Development, Department of Mental Health, Mental Retardation and Substance Abuse Services, Department for the Rights of Virginians with Disabilities, Department of Social Services, Department of Transportation, Governor's Employment and Training Department, and the Department of Medical Assistance Services.

Results

Existing Interagency Groups with Descriptions - The following interagency boards, committees, councils, workgroups were reported to exist as of November, 1994. The descriptions come from the information provided by the state agencies.

Consumer Service Fund Application Review Team - reviews applications submitted to the Consumer Services Fund for funding.

Department of Rehabilitative Services Long-Term Rehabilitation Case Management Advisory Committee - advises DRS on programmatic issues, policies, procedures and client selection regarding Long-Term Rehabilitation Case Management.

Disability Services Council - oversees the activities of the Disability Services Boards.

Governor's Job Training Coordinating Council - oversees the implementation of the jobs training partnership act in Virginia.

Interagency/Consumer Task Force for Individual and Family Support Services - determines and assesses cost-effective methods to support families who are the primary caregivers to children with severe disabilities and fragile health conditions or adults with severe cognitive, physical, and sensory disabilities to reduce or avoid institutional placement and increase employment opportunities.

Personal Assistance Services Policy Advisory Board - reviews Personal Assistance policies.

Rehabilitative Services Incentive Fund Interagency Team - reviews applications to the fund.

Specialized Transportation Council - develops a state plan to quantify the need for specialized transportation among Virginians who cannot drive because of age, disability, or income; describes and analyzes the resources available to meet the needs; lists policy options which will provide incentives to meet needs; and preserves local autonomy and flexibility in the development of coordinated systems which meet local needs.

State Rehabilitation Advisory Council - advises DRS regarding the delivery of vocational rehabilitation services in Virginia.

Statewide Independent Living Council - joint authority between the Department of Rehabilitative Services and the Department of the Visually Handicapped regarding the Virginia State Plan for Independent Living.

Virginia Board for People with Disabilities - promotes and facilitates independence, productivity, family support and community participation of people with disabilities through advocacy, education and prevention initiatives.

Virginia Council on Assistive Technology - advises the Virginia Assistive Technology System on the expansion and delivery of assistive technology information/education and services in Virginia.

Virginia Council on Traumatic Brain Injury (formerly the **Virginia Head Injury Council**) - advises state agency personnel and policy makers on issues related to the needs of persons with traumatic brain injury.

Virginia Institute on Developmental Disabilities Advisory Board - advises the Virginia Institute for Developmental Disabilities on ways to carry out its mission.

Virginia Interagency Coordinating Council for Early Intervention - advises and assists the lead agency (DMHMRSAS) in the implementation of Part H of the Individuals with Disabilities Act (IDEA) responsibilities.

Virginia Intercommunity Transition Council - works to improve transition from secondary education to adult options for youth with disabilities.

Existing Interagency Groups - Status Unknown - A number of groups were identified as currently in existence. No additional information was provided regarding the status of the particular group.

Governor's Dual Party Relay Service Advisory Board
Plan of Cooperation Development Committee
Protection and Advocacy for Mentally Ill Individuals Council
State Special Education Advisory Committee
Virginia Occupational Information Coordinating Committee
Virginia Schools for the Deaf and Blind Advisory Committee
Virginia Board for Rehabilitative Services

Interagency Groups - Existence and Status Unknown

Virginia Mental Health Planning Council
Caregiver's Steering Committee
Deaf and Hard of Hearing Community Counseling Service

Department of Emergency Services Special Populations Committee
Department of Rehabilitative Services Higher Education Work Group
Interpreter Programs Advisory Committee of the Department for the Deaf and Hard of Hearing
Statewide Information and Referral Technical Assistance Committee
Telecommunications Relay Service Advisory Board
HIV Care Consortia
HIV Prevention Community Planning Committee
Long Term Care Council
Part H Interagency Management Team
Advisory Committee on Services to Deafblind Children
Virginia Consortium on Deafness.

Plan of Cooperation - Although not currently in an active status, the Plan of Cooperation has indirectly influenced many of the current activities being undertaken as a result of Disability Commission recommendations. The Plan was developed in response to the enactment in 1985 of the Virginians with Disabilities Act. In order to accomplish this new policy initiative, the General Assembly directed the Governor, the Board for Rights of the Disabled (now the Virginia Board for People with Disabilities), and 11 designated state agencies "to provide in a comprehensive and coordinated manner which makes the best use of available resources, those services necessary to assure equal opportunity to persons with disabilities in the Commonwealth" (Section 51.01-1 of the Code of Virginia). The Plan of Cooperation was developed and finally signed by all identified agency heads in 1986. It was updated in 1987 and member agencies were surveyed in 1988 regarding data collection efforts.

It is unclear as to why there is currently no action related to the Plan of Cooperation. Although never formally disbanded, the Plan of Cooperation Development Committee has not met since at least 1993. A few of the state agencies included participation on the Plan of Cooperation Committee, while other agencies did not include it on their list of interagency groups.

Conclusions

Many interagency boards, committees, councils, and workgroups currently exist that have accomplished many of the objectives of the Disability Commission. Examples are the Virginia Intercommunity Transition Council, the Specialized Transportation Council, and the Virginia Interagency Coordinating Council for Early Intervention. Some of the groups identified may not be currently active, although their status has not been confirmed by the state agencies in the information provided to the Secretary of Health and Human Resources.

Insufficient information was available regarding the purpose of any interagency groups to assess accomplishments or benefits in relation to the investment of staff time and other costs. Therefore, each group must be independently judged as opposed to assessing the impact of interagency efforts as a whole when examining the activities of the past few years. It is also not possible to assess the activities of these interagency groups in relation to the Plan of Cooperation. The Plan of Cooperation, a focal point of interagency collaboration identified within the original Disability Commission report, is definitely not active, but the reasons for this are not clear.

Evaluation of the Efficiency of Existing Information and Referral (I&R) Programs

Since its inception, a major focus of the Disability Commission has been on the awareness of and access to services and programs needed by people with sensory and physical disabilities. A charge of this Disability Services Evaluation was to assess the efficiency of existing Information and Referral (I & R) programs in providing an effective point of entry and in meeting the transition and continuing service needs of consumers. To provide up-to-date information, staff contacted all known I & R systems which are operated by, supervised by, or provided technical assistance by Virginia State Agencies. The identified Information and Referral Systems that are the subject of this report are specified in Table 4-1. It should be noted that there are also a number of independent, local information and referral systems that are used by people with disabilities that operate within Virginia, but none of these systems have been incorporated into this evaluation. An example of such a system is Project Word which limits its scope to the northern Virginia/Washington, D.C. area.

Methodology

Evaluation of the state agency supported information and referral systems consisted of two components. The first was the collection of materials and documents from the different systems and an assessment of the information received regarding: 1) the purposes and functions of the various I&R systems; 2) current technology used by these systems; 3) the provision of follow-up contacts; and 4) outreach efforts to inform the public about their systems. Telephone and/or personal contact was initially made with contact persons at each state agency during the Fall of 1994 in conjunction with HJR 83. Contact was again made in the Summer of 1995 with the contact person or their designee to update information about the current status of each of the I&R systems.

The second component was the development of specific scripts and scenarios which were used by volunteers who contacted various I&R systems throughout the state. Twelve consumers were invited to attend a work group session to develop scenarios. Five consumers attended the work session on July 12, 1995, at which time they used an outline to develop 7 different scenarios. In August, 1995, 3 consumers made the telephone calls to the I&R systems using the 7 scripts and scenarios developed by the work group. Six of the scenarios required at least 3 phone calls be made and the remaining one scenario required 2 calls. The callers were instructed not to identify themselves as an evaluator, and to not give out the telephone number from which they were calling. Prior to any calls being made, evaluation staff contacted each state

Table 4-1
Information and Referral Systems

Telephone #	Description of I&R System	Contact
1-800-230-6977 Statewide Access 1-800-544-2155 Richmond/Southside 1-800-223-2086 Tidewater (703) 642-0700 Northern VA 1-800-227-2053 Northwestern VA 1-800-354-3388 Southwest VA 1-800-255-3337 Central VA	**Virginia Statewide Human Services Information and Referral System** - is provided oversight by the Information and Referral Council which is appointed by the Secretary of Health and Human Resources. It is funded and supervised by the **Department of Social Services.** The system operates using the United Way database through six independent regional centers. The regional centers collect, maintain and disseminate information to callers, walk-ins and persons requesting information by mail. Until 1994, the Centers were not computer linked for communication. Centers usually provide only service/agency names and phone numbers, but often check back with callers to see if services have met their needs. In 1995, the Statewide I&R System implemented a uniform voice and data communications system that shortens the time needed to conduct service searches and improve linkages. The first major improvement of the system's capabilities was the establishment of a statewide toll-free number.	Zandra Thompson 692-2202

1-800-435-8490 Voice/TTD 1-800-238-7955 Modem See ATTACHMENT for telephone #s of CILS	**Virginia Assistive Technology System** (VATS) - provides information on assistive devices and service providers. Also operates a computer bulletin board primarily for consumers to share information on used equipment and need for devices. Accessed by 1-800 number or computer modem (9600 BPS 8N1). I & R is centralized, but requests can be received and handled by the 4 VATS regional sites. **Centers for Independent Living** - the nine CILs and the Woodrow Wilson independent living center all do information and referral. Some have staff assigned for I & R. Both VATS and the CILS are operated through the **Department of Rehabilitative Services.**	Ken Knorr 662-9990 Theresa Preda 662-7000
1-800-552-3402	**Aging Information and Referral System** - operated by the 25 Area Agencies on Aging. **Department for the Aging** provides technical assistance. Some have computer capabilities, others use a printed manual for I & R. Staff are cross trained, so all can handle I & R calls. Information maintained by each AAA is specific to the region.	Faye Cates 225-2271

1-800-552-3969	**Department for Rights of Virginians with Disabilities Database** - database for I&R no longer in use due to archaic hardware and limited usefulness. The bulk of calls that come to DRVD involve more than the exchange of a name and phone number and are handled by all agency staff. Many of the calls involve education, employment issues, or questions about financial entitlements. DRVD is in the process of developing a customer service unit which will handle all incoming calls and be able to respond more rapidly and uniformly to caller questions.	Sandra Reen 225-2042
1-800-234-1448	**FIRST STEPS: Part H Central Directory** - a federally required component of the Part H system. DMHMRSAS, the Part H lead agency, contracts with DRVD to provide information about public and private early intervention services, resources, and experts available in Virginia. Also provides information concerning research and demonstration projects, and professional and other groups that provide assistance to Part H eligible children and their families. Updated annually and available to all geographic regions of the state.	
1-800-435-8490 Voice/TDD	**Department for the Deaf and Hard of Hearing** - I & R is handled by the telephone receptionist in the Central Office, the staff librarian, and by outreach specialists that operate out of regional offices.	Leslie Hutcheson 225-2570

1-800-662-2155 Voice/TDD	**Department for the Visually Handicapped** - In the past, there has been an intake worker in each of regional office who has handled I & R requests. If person who calls DVH is not eligible for services, the intake worker makes a referral to an appropriate agency.	Joe Bowman 371-3144

agency contact person to inform them that calls would be made to their I&R systems based on the scenarios. A qualitative analysis was conducted by staff based on the results of the telephone calls.

Participants

The collection of descriptive materials and data, as well as the telephone calls made to solicit and discuss the material was done by evaluation staff with the contact persons or designees from each of the state agencies.

As previously stated, the scenarios were developed by a work group of 5 consumers and telephone calls made by 2 of the work group members plus one consumer who was invited but could not attend the work group session. Consumers were reimbursed for the services they provided through Personal Service Agreements which covered the costs which enabled their participation such as personal service attendants and transportation, as well as coverage of any distance telephone charges. Persons who were on the receiving end of the telephone calls made to the I&R systems, were those individuals who would normally take such calls. None of these individuals knew that the callers were using previously developed scenarios.

Results

The information contained in the materials sent by the state agencies show wide variation in how the I&R services are provided and the data that is collected. For example, the largest of the I&R systems, the Statewide Human Services Information and Referral System, collects and regularly reports data regarding the total number of calls, can identify the requests by service category, requires follow-up with at least 10% of the calls made to each regional site, and conducts internal and external evaluations of the system. The information and referral system available through the Virginia Assistive Technology System similarly does follow-up contacts and collects regional data, but has not done an analysis of the data since 1993. VATS, does though have the added advantage of having a system that can be accessed through computer modem and has an available computer bulletin board. All of the other I&R

systems currently depend on written resource manuals or less sophisticated computer software to be able to provide I&R.

There is also variation among the I&R systems in how units of service are defined and reported. Most of the systems define a unit of service as a call received, but the CILS define a unit as an hour. The Area Agencies on Aging use a units of service category for reporting purposes as well as number of people served and various demographics about the population. One of the systems does not track or report on the calls it receives requesting information; it only collects data on calls regarding potential intake for admission into agency services.

All of the I&R Systems except for the Centers for Independent Living have statewide toll free access numbers. The Department for the Aging, Department for the Deaf and Hard of Hearing, and the Department for the Visually Handicapped, as well as the Department for Rehabilitative Services (for the CILS) will provide the caller with the number of the local/regional office closest to them. There is an issue facing the Statewide Human Services Information and Referral System regarding provision of widespread publicity of the statewide access number. Data supports that if there is a 25% increase in the number of calls being made to the regional sites due to increased publicity, a significant number of callers could be placed on hold for increasing lengths of time or would be unable to reach the I&R number because of the line being busy.

Actual contacts with the I&R systems done through the scenarios developed and used by consumers supported the material review findings that there were many differences among the I&R systems. There were also inconsistent responses within the same I&R system. For example, of the seven contacts made with the Statewide Human Services Information and Referral System, five were with different regional centers. Two different consumers contacted a single regional center with two different scenarios. One of the scenario contacts was considered to be very helpful with accurate and complete information being given, while the response to the other scenario was considered to be only fair with the person from the I&R system not thought to be considering the "whole" of the request.

Table 4-2 illustrates how the consumers rated the responses to the calls they made to the I&R Systems. Data was collected on a total of 20 calls that were required by the seven scenarios. At least one call was made to each of the I&R systems included in this evaluation.

Qualitative data from the results of the telephone calls made to the I&R systems were rated by staff as being high quality, medium quality, or low quality. For the most part, the consumers thought that the individuals who answered the calls were helpful and understood what was being requested. Only one of the I&R contacts did not to give any information, and one was unsuccessful because someone was on vacation. Two of the consumers were put on hold while waiting for information; one was for five minutes and the other was for 4 minutes. At least three of the contacts resulted with a plan for a call back for additional assistance.

Table 4-2
Consumer Ratings
N=20

Factor	High	Medium	Low
Helpfulness of person answering call	8	9	3
Understanding of what was being asked	14	4	2
Accuracy and completeness of information	7	6	7

Conclusions

It would be extremely difficult to do any comparative analyses among the I&R systems supported by state agencies due to the variability in scope of information, role of the person receiving the request for information, and data availability. This variability has been demonstrated with both the written material reviewed and the telephone contacts made with the systems. It is clear that consumers can get excellent information from very helpful people who answer the telephones who will follow-up on the initial contact to make sure that the consumer gets what is needed. But other consumers can call the same I&R system with a similar need and receive very little information. It depends on when the call is made and the knowledge of the person who handles the request. This is especially true for those agencies that have an I&R component, but it is only a small part of the overall scope of service delivery. Better preparation of staff and easily accessible resource information would certainly improve consistency within each system.

This evaluation has confirmed that there are statewide I&R systems in Virginia. The largest, the Statewide Human Services Information and Referral System is an easily accessible resource for persons with sensory and physical disabilities. Unfortunately, there is fear that by increasing awareness of how to access this system through its new statewide toll free number, the system will be quickly overwhelmed. If this fear is founded, it would mean that I&R systems are currently meeting only a fraction of the need for disability specific as well as general service information.

Evaluation of the Implementation of Commission Administrative Recommendations

In its 1992 Report, the Disability Commission made 95 specific recommendations that required involvement and action by a number of state agencies. These recommendations focused on the program, services, and resources of public agencies serving persons with physical and sensory disabilities.

Methodology

Secretary of Health and Human Resources, Kay Cole James, in response to HJR 83, requested an update from the heads of state agencies on progress and activities undertaken in implementing the administrative recommendations. Information was requested relative to the progress made or activities undertaken to accomplish each recommendation.

The Disability Services Evaluation Task Force was charged with assessing the implementation of the recommendations based on the responses given by the state agencies to Secretary James. The recommendations and their responses were sorted by staff according to the secretariat or agency cited as being responsible. Each response was given one of 4 ratings: accomplished; action, partially accomplished; action, not accomplished; or no action. A summary of the administrative recommendations contained in the Commission Report, as well as agency responses to those recommendations, are contained in Attachment #1.

Participants

Responses were received from the following state agencies. It should be noted that there was not a response to every recommendation.

Department of Rehabilitative Services (DRS)
Department of Medical Assistance Services (DMAS)
Department for the Deaf and Hard of Hearing (VDDHH)
Department for the Visually Handicapped (DVH)
Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS)
Department for the Rights of Virginians with Disabilities (DRVD)
Department for the Aging (VDA)
Virginia Housing Development Authority (VHDA)
Department of Housing and Community Development (DHCD)
Department of Health (DOH)
Governor's Employment and Training Department (GETD)
Department of Education (DOE)

Center for Innovative Technology (CIT)
Department of Social Services (DSS)
Joint Board Liaison Committee (JBLC)
Department of Planning and Budget (DPB)

Results

State agencies responded to 63 (66%) of the 95 administrative recommendations. A total of 31 of the recommendations have been accomplished, with an additional 5 accomplished by a majority of the agencies listed as responsible for the specific recommendation. Added to these 36 recommendations that have been successfully achieved are 17 recommendations that have had action and partial accomplishment for a total of 56% of the 95 recommendations having a positive outcome. There were only 2 of the recommendations that were reported as not having had action.

Accomplishments

Significant action has been taken to implement a large number of recommendations contained in the original Commission report. Illustrative examples of recommendations which have resulted in significant accomplishments, as reported by the responsible agencies are provided below.

- Establishment of the Disability Services Council, Disability Services Boards, Consumer Services Fund, Rehabilitative Services Incentive Fund, Personal Assistance Services, Special Transportation Council, and the State Library for the Visual and Physically Handicapped.
- Statewide expansion of Long-Term Rehabilitative Case Management
- Cost of living increases for Centers for Independent Living (CILS) and establishment of the Independent Living Evaluation System.
- Legislation that provides quality standards for interpreter services.
- Availability of alternative media for people with blindness.
- Continued use of the deafblind tracking system.
- Legislated sanctions against those who abuse or neglect persons who are elderly or disabled.
- Revised immunization certificate and health manual for use by public schools.

- Improved preparedness of emergency medical service personnel that enables them to respond to the emergency needs of people who are deaf, hard of hearing, speech impaired, deafblind or visually impaired.

- Development of assistive technology through cooperative agreements with the Center for Innovative Technology.

- Increased public awareness and program evaluation/quality assurance of programs providing services to individual with sensory and physical disabilities.

- Use of client satisfaction surveys by state agencies.

Recommendations Which Have Not Been Implemented

In a number of areas, the specific recommendations of the Disability Commission have yet to be addressed. Examples of these recommendations include:

- Establishment of a Rehabilitative Services Interagency Team.

- Development of a program to recruit, train and coordinate a statewide corps of volunteer drivers to provide transportation.

Recommendations For Which Limited Information is Available

Some of the recommendations included in the original Disability Commission Report involve multiple agencies working cooperatively. Other recommendations suggest policy directions while not identifying specific implementation steps. For several of these recommendations, information is not presently available.

- Development of cross-agency and inservice training designed to promote local interagency activities and involvement of consumers in service development.

- Establishment of task force to study need for criteria, preparation, and qualifications of reimbursed case managers.

- Examination of eligibility requirements of services for persons with physical and sensory disabilities.

- Development of uniform intake assessment instruments and standard service definitions.

- Development of strategies for interagency coordination and proposals for interagency services through the Plan of Cooperation.

* Determination whether consolidation of CSBs and DSBs is feasible.

* Study of issue of co-location of services and determination if standardization of geographic divisions are essential to the success of co-location.

* Independent evaluation of all state agency programs serving persons with physical and sensory disabilities.

* Investigation of the use of tax incentives and liability waivers to encourage volunteer drivers, increased recognition and training for community volunteers.

* Recommendations specific to public schools and services to students receiving or exiting from special education services.

* Study the feasibility of a special appointment system for people with disabilities seeking state jobs.

* Development of a proposal for the creation of a university consortium to address training for service providers, research, and technology transfer for purposes of promoting prevention and early intervention.

* Development of plan for providing affordable and accessible medical services to persons with physical and sensory disabilities.

Conclusions

After examining the many activities and actions reported by the heads of the state agencies in response to the Disability Commission's recommendations, it is clear that there have been many accomplishments that have affected the lives of individuals with sensory and physical disabilities. Pilot projects and direct services have been expanded; existing resources have been creatively used to increase access to needed services and equipment; and interagency collaboration continues, although perhaps not always on a formal or consistent basis. Through its initial recommendations, the Disability Commission has had a lasting impact on the service system by facilitating the activities that serve to improve the lives of Virginians with sensory and physical disabilities.

Summary of Findings and Conclusions

The following section summarizes the major findings and conclusions of the Disability Commission Evaluation in each of the five areas identified in HJR 83.

1. The Disability Services Council and Disability Services Board network;
2. Prior and current funding initiatives of the Disability Commission;
3. Current interagency committees, task forces, and work groups addressing the needs of individuals with disabilities;
4. Information and referral systems operated by state and local agencies;
5. Administrative recommendations contained in the initial report of the Disability Commission.

Evaluation of the Disability Services Council and the Disability Services Boards

The results of the evaluation of the Disability Services Boards (DSB) and the Disability Services Council (DSC) provide a picture of a service coordination system still in its early stages of growth and development. Some Boards are further along in their work than others. Most significantly, in some areas of the state there do not appear to be fully operational Boards. In these localities, meetings of the Boards are being held infrequently, if at all. Plans are not being implemented and the recruitment of qualified and interested individuals to serve as Board members has been difficult. Despite the challenges faced by the DSBs, in general they believe they are making an impact in their localities that will enable individuals with physical and sensory disabilities to more fully participate in their communities.

DSBs have primarily focused their activities on transportation services, accessibility issues, conducting their needs assessments, improving services for individuals with hearing impairments, and housing issues. Increasing community awareness, enhancing community services, and developing a RSIF proposal are identified most frequently as DSB accomplishments. The Boards have been able to implement a range of activities to meet their ADA resource and referral duties. They believe that identifying individuals who are willing and committed to serve on the Board plays a critical role in the success of the Boards. The members expressed a need for additional resources to enable them to achieve their goals and the need for continuing clarification about their role and ongoing communication with agencies, organizations, and groups concerned about the needs of individuals with physical and sensory disability.

The majority of current DSC members have served on the Council for one year. The Council members believe that more needs to be done to insure that the DSC and DSBs share information in an effective and timely manner. They indicate that in their view support services need to be better organized and more education should be provided to DSB members about purpose and activities of the Council.

The DSC members are clearly aware of the issues and challenges facing the Disability Services Boards. They emphasize the need for Boards to find active and committed members. The Council recognizes that the Boards are at various stages in their development and believe that an organization of DSBs would further assist the Boards in providing support and technical assistance through the exchange of ideas and information. In conclusion:

1. **There is wide variation across the state as to the development and implementation of the Disability Services Boards.** The evaluation results do not present a uniform picture of the DSBs, but rather illustrate the various stages in their development and ability to carry out their responsibilities. While many localities possess active and vibrant Boards, in several areas of the state the DSB has yet to become fully operational. DSB members believe there is a need for more staff support, clarification of the Board's responsibilities, and increased communication with the public about the Boards and among the various parties involved with the Board. Disability Services Council members believe that the Boards need either further assistance or staff support to assist them in meeting their intended purpose. The Council would also like to see effective DSBs used as models for other Boards to assist in the development of goals and implementation plans.

2. **The DSC members believe that the DSBs are meeting their original purpose and should not be redefined.** The members believe there is a need for clarification of the DSBs' role and a need to include more consumers. The Council believes that the Boards are in the formative stage and need more time to develop and become established.

3. **Greater sharing of information between the DSC and the DSBs needs to be accomplished in an effective and timely manner.** The Council members expressed the need for support services to be more organized and for further education or orientation activities for DSB members to better understand their role and the role of the Council. DSB members are unclear about the DSBs' relationship with the Council and the amount of support and guidance the Council can provide.

4. **The DSB members need further clarification and refinement of their responsibilities and authority.** Administrative issues identified by a sizable number of respondents included the need for better orientation of Board

members and a clearer understanding of the amount and type of assistance which the Department of Rehabilitative Services can provide.

5. **Local government has been supportive of the DSBs' efforts to establish the Boards and implement their activities.** A majority of the DSBs participating in the evaluation have received assistance and support from their local governments in the form of furnishing staff support, responding to request or initiatives of the DSB, and obtaining meeting space and interpreter services.

6. **The DRS liaison plays a key role in providing the DSBs information and an understanding of the other organizations and agencies involved with the Boards.** A critical factor which impacts the DSBs' members perceptions of the support they receive from the Department of Rehabilitative Services is the DRS liaisons and their relationship with the individual Boards. DSB members who believe that their Board received the guidance and support they needed from DRS focused their comments on the work done by their liaison.

7. **The DSC believes that an organization of DSBs would further assist the Boards in providing support and technical assistance.** All of the Council members interviewed felt that the creation of a statewide association of DSBs is needed. They believe an association would enable members to exchange ideas and information, network with other DSBs, and provide a mechanism for technical assistance and support to the Boards.

Evaluation of Funding Initiatives

Consumer Services Fund

The guidelines established for the Consumer Service Fund are responsive to its intended purpose. Approximately 190 applications per year are received for funding. The application review process effectively screens applications for need based on the 'fund of last resort' principle that guides the Consumer Services Fund. The allocation to the Consumer Service Fund is fully utilized to provide a wide array of services to a population representative of persons with physical and sensory disabilities. Overall conclusions from this evaluation are:

1. **The Consumer Services Fund is effectively managed and appears to be fulfilling its intended purpose.** Approximately 180 individuals with physical or sensory disabilities have received services through the fund since its initiation at the start of FY 1994.

2. **Because of the short term nature of service intervention through the Consumer Services Fund, it is difficult to evaluate the longer term impact of these services.** Funded services do appear to be addressing situations where there is a need for "extraordinary services beyond the scope/capacity of local service agencies" as called for in the fund guidelines.

3. **Complete information is not available regarding the specific number of unfunded applications that met funding criteria but were turned down by the CSF screening committee because of lack of funds.** Without this information, it is difficult to establish the extent of the unmet need for the assistance provided through the Consumer Services Fund. Unfunded applications to date should be further reviewed to determine the number of these applications that fall into the unmet need category.

Rehabilitative Services Incentive Fund

A comprehensive evaluation of the impact to date of the Rehabilitation Services Incentive Fund (RSIF) is not possible because this program is currently in the process of completing the initial funding of awards to Disability Services Boards. All implementation activities to date are supportive of the RSIF achieving its purpose. It is important to note that the $500,000 RSIF appropriation leverages additional funds and support at the local level through the match process. For FY 1996, the first year of RSIF funding, that match total will be over $300,000. Future evaluations of the RSIF should consider the following points:

1. **In a number of instances, the RSIF DSB allocations and award levels involve small amounts of funds. Consideration is needed as to whether the $1,000 minimum allotment for a DSB establishes a "critical mass" of funds to allow for a significant impact on rehabilitation services in a community.** The funding formula established for this program does appear balanced in terms of allotting funds to mid- to large- size communities. Particular evaluation attention is needed to the impact of the RSIF in small communities, which frequently have limited resources and cover large geographic areas. Options such as raising the minimum allotment or setting aside funds for a limited number of high priority projects which have funding requirements beyond the allotted funds for a specific DSB could be considered in future reviews of the RSIF.

2. **The RSIF is consistent with the DRS effort to decentralize services and to support community service development.** Future evaluations of this program should emphasize measurement of the actual impact achieved by funded projects and the ability of communities to maintain and to further develop initiatives generated with RSIF support. There is a very positive history in Virginia of establishment grant funding systematically improving over time the

availability and quality of services. The grant funding strategy worked effectively in Project UNITE, the Virginia Assistive Technology System (VATS), and the 5 year statewide supported employment systems development project.

Personal Assistant Services

The Personal Assistance Services program served 105 individuals with disabilities during Fiscal Year 1995. There are 300 individuals who are on a waiting list to receive services. Fiscal Year 1995 appropriations for the program totaled $739,000, an increase of $189,000 from Fiscal Year 1994. Most recent available information indicates that the average annual cost of PAS services is $5,580 per individual.

The consumers who participate in the DRS Personal Assistance Services program have significant disabilities and are likely to have a health condition or existence of a disability other than their primary disability. These participants receive more paid hours of care than those individuals on the PAS waiting list and do not spend a significant portion of their personal funds to receive these services. Because those on the waiting list spend a substantially higher percentage of their own funds on personal assistance, the data suggest that the PAS program helps reduce a significant financial liability on the consumer, as well as provide support to unpaid family caregivers. In conclusion:

1. **The PAS program has a dramatic impact on the independence and productivity of participants.** PAS participants are more likely to use preventive health care services and spend more time during the week outside of their homes. PAS recipients are employed at twice the rate of those on the waiting list, despite the finding that PAS participants appear to have more severe disabilities.

2. **While available to individuals in all areas of the state, the PAS program is only meeting a small percentage of the identified need.** Presently, 300 individuals who meet program admission criteria are presently awaiting services.

Long Term Case Management Program

The Long Term Rehabilitative Case Management (LTRCM) Program has been in place since 1989. Two separate studies were completed in FY 1994 involving LTRCM participants. The first, a telephone interview study of participant satisfaction indicated that approximately 78% of persons surveyed reported being completely satisfied with the services received. The results of this survey indicated that LTRCM participants were satisfied with the coordination services they received and believed that these services had improved their rehabilitation situation. The second study compared active LTRCM participants and individuals on the program's waiting list to determine whether individuals receiving LTRCM services were linked to more service resources than individuals on the waiting list. Results of this study indicated that LTRCM participants were linked to an average of four more service resources (13.9 compared to 9.3) than individuals on the waiting list. Evaluation conclusions are as follows:

1. **The Long Term Case Management Program is assisting approximately 140 persons with physical disabilities access a wide array of community based rehabilitation services at a cost of approximately $2,000 - $2,500 per person per year.** There are positive indications that the LTRCM Program is providing services in a manner satisfactory to service recipients. The LTRCM is effectively fulfilling its purpose with those individuals who are being served.

2. **Recent program data indicate that the LTRCM Program is able to assist approximately 20-25 new participants per year.** Because of the long term support needs of program participants, there is a limited capacity to serve new participants. The current waiting list of 58 persons for services is an indication of the need for the services provided through this program.

Cognitive Rehabilitation Program

The Cognitive Rehabilitation Program (CRP) is providing cognitive rehabilitation services to individuals consistent with the targeted population and program purpose. On balance, the response to the program by service recipients, service providers, and other participants is positive. CRP representatives have taken appropriate steps to strengthen the program based on the formal evaluation of the first year (FY 1994) outcomes. It is important to note the following reference in the evaluation report for FY 1994 from Drs. Ball and Schlegel:

> "There are many areas in which services might have been delivered more efficiently, and some gains for those participants may have had more to do with interagency communication and cooperation and with concerted attention to someone's needs than with specifics of cognitive rehabilitation services. Nonetheless, in each instance there is now some diminished risk of institutionalization, greater vocational readiness, further community integration, and an enhanced recovery from TBI. DRS case managers and private service providers proved themselves able to work together productively, sometimes in a particularly creative and exciting fashion." (p. 60)

FY 1995 participant outcomes appear consistent with this evaluation of FY 1994 results. The Cognitive Rehabilitation Program does appear to be achieving its purpose of assisting individuals with an acquired brain injury to achieve greater community integration, live in a less restrictive environment and move forward in their rehabilitation process. It is difficult, however, to factor out specifically the contribution of cognitive rehabilitation services within the entire array of services provided to program participants. Evaluation conclusions are as follows:

1. **Funds for this program are used to purchase cognitive rehabilitation services.** There is not sufficient data available to measure the true contribution these specific services are making to improvements in the quality of life of program participants.

2. **The annual appropriation for the CRP program is $200,000, and services are provided to 6-8 individuals.** Costs per participant are in the range of $25,000 to $30,000. Sufficient data is not available to determine the cost/benefit to this program because of (a) the difficulty referenced above in determining the extent to which cognitive rehabilitation services are contributing to participant outcomes and (b) the general, qualitative nature of these outcomes, such as greater vocational readiness and enhanced recovery from TBI.

Evaluation of the Accomplishments and Effectiveness of State-Level Interagency Committees

The myriad of interagency committees that currently exist in the Commonwealth must be judged independently, as opposed to assessing the impact of collaborative efforts as a whole when examining state agency activities during the past few years. A vehicle for interagency collaboration and cooperation, the Plan of Cooperation, did operate from 1986 until several years ago. While inactive, the Plan of Cooperation Committee has not been formally disbanded. Consideration should be given as to whether current interagency communication channels are sufficient, or whether the Plan of Cooperation Committee should be revitalized. Evaluation conclusions are as follows:

1. **Many interagency boards, committees, councils, and workgroups currently exist that have accomplished many of the objectives of the Disability Commission.** Examples are the Virginia Intercommunity Transition Council, the Specialized Transportation Council, and the Virginia Interagency Coordinating Council for Early Intervention.

2. **The Plan of Cooperation, a focal point of interagency collaboration identified within the original Disability Commission report, is definitely not active, but the reasons for this are not clear.**

Evaluation of the Efficiency of Existing Information and Referral (I & R) Programs

It is clear that consumers can get excellent information from very helpful people who answer the telephones at the I&R systems that were examined in this study. But other consumers can call the same I&R system with a similar need and receive very little information. There exists variability in scope of information, role of the person receiving the request for information, and data availability. Better preparation of staff and easily accessible resource information would certainly improve consistency within each system. Major conclusions of the evaluation are as follows:

1. **Currently, there does not exist a statewide I&R system capable of handling all of the potential calls from individuals with sensory and physical disabilities.** This is demonstrated by the fact that there is concern that if awareness were increased, the quality of services provided by the Statewide Human Services Information and Referral System would be diminished by the overload generated by an increased number of calls.

2. **By all accounts the state's present information and referral network is only addressing a fraction of the current needs.** An expansion of present program capacity, as well as improved coordination between the two largest computerized systems, Human Services and VATS, could assist in establishing an up-to-date and accurate I&R system that is easy to access by the public.

Evaluation of the Implementation of Commission Administrative Recommendations

Significant action has been taken to implement a large number of the recommendations contained in the original Disability Commission Report. Pilot projects and direct services have been expanded; existing resources have been creatively used to increase access to needed services and equipment; and interagency collaboration continues, although perhaps not always on a formal or consistent basis. Major conclusions resulting from the evaluation are as follows:

1. **The administrative recommendations contained in the original Disability Commission Report stimulated a great deal of activity among Virginia state agencies.** Many of these recommendations resulted in direct agency actions that have led to modifications in the service delivery system for individuals with physical and sensory disabilities.

2. **It would be beneficial to examine the recommendations that did not receive a response from the state agencies responsible for implementation.** These,

together with the recommendation activities which are coordinated through the Office of the Secretary of Health and Human Resources would provide a more complete record of the successes achieved over the past few years.

Attachment #1

Recommendations from the Final Report of the Commission on the Coordination of the Delivery of Services to Facilitate the Self-Sufficiency and Support of Persons with Physical and Sensory Disabilities

RECOMMENDATIONS FROM THE FINAL REPORT OF THE COMMISSION ON THE COORDINATION OF THE DELIVERY OF SERVICES TO FACILITATE THE SELF-SUFFICIENCY AND SUPPORT OF PERSONS WITH PHYSICAL AND SENSORY DISABILITIES

The Disability Services Evaluation Task Force was charged with assessing the implementation of Commission recommendations that require administrative action by involved state agencies. The recommendations come from **House Document No. 11, Commonwealth of Virginia, Richmond, 1992.**

RECOMMENDATIONS DIRECTED TO THE SECRETARY OF HEALTH AND HUMAN SERVICES (HHR)

1.1.1 The Secretary of HHR direct DRS, in coordination with the Council on Assistive Technology, to complete a study on developing a mechanism to establish an adaptive equipment loan financing program by May 1, 1992, with implementation by July 1, 1993. The adaptive equipment loan program shall include purchase of hearing aids. (p. 12)

The study was completed in 1993 and a recommendation for a loan financing program for Virginia was introduced to the 1994 General Assembly session through a budget amendment. The budget amendment was not funded. A bill (SB 985) was introduced and approved by the General Assembly in 1995 to create an Assistive Technology Loan Fund Authority. No state funds have yet been allocated to the Loan Fund, but a study resolution (SJR 333) will be looking at ways to fund the Fund.

1.1.2 A Rehabilitative Services Incentive Fund will be established to support local investment in community programs and services for persons with physical and sensory disabilities. Such funds will be allocated to planning boards to be matched by local funds on a formula basis. The Secretary of HHR will develop the formula by November, 1991. Enabling legislation will by introduced to allow localities to establish local funds to match the State Rehab Services Incentive Fund. Such language will be permissive as an incentive to local investment. (p. 48)

Guidelines for the Rehabilitative Services Incentive fund were approved by the Disability Services Council in December, 1993. Funds began to be appropriated to the fund in 1994 and are allocated to the local boards based on census information as well as other local demographic data.

1.1.3 The Secretary of HHR direct DVH to conduct a study on the extent of the need and the fiscal impact for the expansion of visual rehabilitation services beyond existing resources. Such study should address the number of individuals affected, the identified existing resources both programmatic and fiscal, and develop a funding proposal to address unmet needs. This study shall include consumer representation and shall be completed by July, 1993. (p. 38)

DVH conducted the study in the spring of 1993. It was determined that there was unmet needs in two areas: 1) there is need for more staff in order to lower the consumer-to-instructor ratio, and 2) more funds are needed to purchase certain services (low vision aids, adaptive equipment) for consumers. The extent of unmet need was difficult to quantify.

1.1.4 Secretary of HHR direct DOH to conduct a study of the limited scope of the Children's Specialty Services Program and address the unmet need in the 1994-1996 biennium. (p. 31)

A study was completed by DOH and unmet needs were identified. Addenda budget requests were made by the program, but none were funded. Also, pursuant to HJR 691 (1993), a plan was developed to incorporate HIV/AIDS Treatment for Infected Children in the Children's Specialty Services Program, but funds were not appropriated by the 1994 General Assembly. However, $250,000 was appropriated by the 1994 General Assembly for the provision of comprehensive sickle cell services.

1.1.5 The Secretary of HHR work with DPT and the human service agencies to develop and implement cross-agency training for state and local administrative and direct service staff designed to promote local interagency activities and resolve administrative barriers to effective local collaboration. Such training will be developed by October 1, 1992. (p. 44)

1.1.6 The Secretary of HHR work with DPB and DPT to develop policies and procedures that will facilitate the formation of multi-agency, jointly administered projects at both the state and community levels. (p. 45)

DPB is and has been available to research policy issues raised by the Disability Commission. For example, DPB reviewed potential costs associated with a draft legislative proposal to create an Individual and Family Support Service System and Consumer and Interagency Coordination Council.

1.1.7 The Secretary of HHR with the assistance of DPT and the human service agencies will develop a comprehensive inservice training program for newly hired employees and for personnel continuing in service. This program should emphasize cross agency awareness and sensitize employees to involving the consumer as a partner in service development and implementation. (p. 69)

1.1.8 The Secretary of HHR direct DSS to submit a plan to increase consumer awareness and accessibility to income support programs. This plan is to be submitted to the Secretary of HHR by June 30, 1992. (p. 66)

DSS has an ongoing awareness program to make customers knowledgeable of the income support programs available to them and considers the existing program sufficient to meet the recommendation.

1.1.9 A Secretarial task force will be established to identify the various levels of case management and study the need for established criteria for the preparation and qualifications of <u>reimbursed</u> case managers. The Commission believes that the task force should be made up of a balance of professional and consumers to effectively address the identified issues. It is also proposed that the Secretarial task force develop a definition for the terms case management and service coordination as well as establish criteria for the preparation and qualifications of <u>reimbursed</u> case managers. The task force will complete its work by July 1, 1992. (p. 14)

1.1.10 The Secretarial task force on case management determine the most cost effective manner of delivering professional case management services (agency staff vs. contracted). (p. 14)

1.1.11 The Task Force on Eligibility and Interagency Information Management of the Health and Human Resources Secretariat:

* examine current eligibility requirements of services for persons with physical and sensory disabilities;

* identify differences in eligibility requirements, the reasons why such differences exist, and the potential to change these requirements within state and federal statutes and regulations; and

* make recommendations to the Secretary of HHR and appropriate agencies for revising existing eligibility criteria to ensure greater consistency by June, 1992. (p. 25)

1.1.12 The Secretary of HHR direct agencies to develop uniform intake assessment instruments, standard service definitions and clear criteria of eligibility and investigate the feasibility of incorporating this instrument into a statewide database for all agencies in the Commonwealth providing services to individuals with disabilities. Such proposal shall be completed by October 1, 1992. (p. 25)

1.1.13 The Secretary's Task Force on Eligibility and Interagency Management be expanded to include consumer representation. (p. 26)

1.1.14 The Secretary of HHR work with appropriate state agencies to develop strategies for inter agency coordination similar to the state Plan of Cooperation that address local coordination issues. Such strategies will be developed by October 1, 1992. (p. 44)

1.1.15 The Plan of Cooperation clearly articulate proposals for interagency services for individuals with physical disabilities and sensory impairments. These proposals should be considered in the development of future biennial budget requests of participating agencies. (p. 45)

1.1.16 The Secretary of HHR monitor changes in Federal legislation and regulations to determine if consolidation of Community Services Boards and Disability Services Planning Boards would be feasible and/or desirable. Consideration should be given to maintaining the integrity of the service system for persons with physical and sensory disabilities and persons with mental disabilities. (p. 49)

1.1.17 The Secretary of HHR continue to maintain contact with HCFA to ensure that the concerns regarding discrepancies in coverage by Medicare are addressed through policy reform. (p. 52)

1.1.18 The Secretary of HHR take the lead responsibility in promoting public awareness and public education programs on services to persons with physical and sensory disabilities. The Secretary should also identify sources of funding, both public and private, to support this effort. (p. 56)

1.1.19 The Secretary of HHR study co-location of services provided by the various human service agencies as a move toward improved access and increased cost effective service provision. Further study may be necessary to determine if standardization of geographic divisions are essential to the success of co-location. The study is to be completed by October 1, 1992. (p. 56)

1.1.20 The Secretary of HHR will complete an independent evaluation of all programs serving persons with physical and sensory disabilities, either state operated or contracted with private non-profit organizations in the DRS, DVH, DRVD, DDHH, DOH, GETD, and DOE biennially or, at a minimum, every four years.

The Secretary should use the Board for Rights of Virginians with Disabilities as a vehicle for contracting for these independent evaluations in accordance with its statutory responsibilities. Rehabilitation outcomes will be assessed and management controls identified and altered as necessary. (p. 62)

1.1.21 The Secretary of HHR will work with appropriate state agencies to establish and implement a biennial process which assesses the extent to which implementation of state agency policies, regulations, procedures, and funding requirements have created barriers to effective local collaboration. Representatives of local service agencies should participate in these assessments and in the development of recommendations to resolve identified barriers. (p. 62)

1.1.22 The Secretary of HHR will assess on a biennial basis the accomplishments and effectiveness of state level interagency committees established to address issues surrounding services to people with disabilities and to report findings to the Governor. (p. 62)

1.1.23 The Secretary of HHR will conduct a study in 1995 to determine the effectiveness of the implementation of recommendations contained in the 1992 final report of the commission and make recommendations for further changes or adjustments that should be made. (p. 63)

In 1994, the General Assembly approved HJR 83 which resulted in the Secretary of Health and Human Resources appointing a task force charged with developing a plan to evaluate the Disability Commission activities in 1995. The task force's final report and recommendations for evaluation methodologies was published in House Document No. 48. Evaluation activities were conducted during the summer of 1995 and results forwarded for further action by the Secretary.

1.1.24 The Secretary of HHR investigate the use of tax incentives and liability waivers or limits to encourage greater participation by volunteer drivers. (p. 74)

1.1.25 The Secretary of HHR establish an annual award ceremony, in conjunction with the Governor's Awards for Volunteer Excellence, which recognizes the contributions made by volunteers to persons with physical and sensory disabilities. (p. 74)

1.1.26 The Secretary of HHR develop a program for training volunteer coordinators in each local human service agency to recruit, train, coordinate and encourage community volunteers. (p. 74)

RECOMMENDATIONS DIRECTED TO THE DEPARTMENT OF REHABILITATIVE SERVICES (DRS)

1.2.1 The regional technology-related assistance centers be funded beyond current federal grant funding. Interagency cooperation and access to service will be improved through this program. Funding proposals should be developed for the 1994-96 biennium. (p. 11)

Regional technology centers were funded with federal dollars. Since the Technology Act was re-authorized, the regional centers have funding through the year 2000, although federal funding begins to be phased out in 1988 and 1999. State funds will be required to continue the centers beginning in 1998.

1.2.2 Expand the DRS Long-term Rehabilitation Case Management project statewide during the 1992-94 biennium with access uniformly available including infants and children with physical and sensory disabilities. Current eligibility criteria for long-term case management as set forth in Section 51.5-9.3 of Title 51.5 of the Code of Virginia will be utilized in determining eligibility for this expanded service. A means test for case management services beyond information and referral will be established by DRS. (p. 14)

The LTRCM Program became a statewide program in February, 1990. Although the program serves primarily adults, there is currently no age limit attached to case management services provided by the LTRCM Program. Individuals who apply for LTRCM services are screened based on the established guidelines by a committee, those not selected are provided technical assistance by the LTRCM Program Coordinator in obtaining appropriate services. The guidelines include a means test.

1.2.3 The Rehabilitative Services Interagency Team will develop guidelines for consumer rights and procedural safeguards as needed to afford protection to consumers by July, 1993. (p. 18)

DRS did not establish a Rehabilitative Services Interagency Team.

1.2.4 Supported employment services will be enhanced through improved interagency collaboration and expansion of supported employment services through the private sector. Access to supported employment for persons with physical and sensory disabilities will be expanded. A means test will be established. (p. 29)

Budget amendments submitted to the General Assembly for on-going dollars to support individuals in supported employment have not been funded. Access has improved with an increase in private supported employment services vendors across the Commonwealth. DRS has established a vendor qualified to provide services for people who are deaf. There does exist a means test for time limited supported employment services, but there is not consistency across the state regarding a means

test for long term supported employment services. This is primarily because supported employment follow along services are funded through several different revenue sources.

1.2.5 Funding for the establishment of one additional CIL each year of the 92-94 Biennium. (p. 36)

Budget amendments have been submitted for the past five years requesting funding for additional CILs, none of which have been funded.

1.2.6 Cost of living increases for CILs be reinstated when the current budget constraints are removed and service providers, both public and private receive such increases. (p. 36)

CILs received cost of living increases of 2% in FY 1993, 3% in FY 1994, and 2.25% in FY 1995. Additionally, in FY 1995, each of the ten CILs received $15,000 to support increased programming.

1.2.7 DRS address funding and program effectiveness issues of CILs utilizing data collected through its Independent Program Evaluation system. The funding request by CILs for $2,762,000 and $3,718,000 based on the 1989 study, should be deferred until the DRS Independent Living Evaluation System is completed. The data provided by this evaluation system will enable DRS to more accurately quantify the extent of unmet need. (p. 36)

DRS developed a CIL data collection system which interfaces with a newly developed CIL evaluation system. Cumulative data will be available from the data collection system in October, 1995.

1.2.8 A Disability Services Council be established to develop guidelines for planning and requests to the rehabilitative services incentive fund and consumer service fund. (p. 44)

The General Assembly established the Disability Services Council (DSC) in 1992 (Section 51.5-47 in the Code of Virginia). The first meeting of the DSC was held in September, 1992.

1.2.9 Local Disability Services Planning Boards will be established to ensure local input on fiscal and programmatic planning for services for persons with physical and sensory disabilities. (p. 48)

Disability Services Boards were established by the General Assembly (Section 51.5-47 of the Code of Virginia) in 1992. There are currently 44 local Boards representing all but one city and one county in the Commonwealth.

1.2.10 A means test should be used for all rehabilitative services, except as prohibited by federal or state laws or regulations. (p. 50)

DRS currently uses a means test for services provided to people with disabilities.

1.2.11 Agencies develop a means test for programs and solicit consumer input into the development of such tests. Means tests should be flexible and take into account the entire spectrum of financial considerations which impact the consumers ability to pay. (p. 50)

DRS developed a means test to implement Executive Order #15, which includes revising the state regulation regarding the means test formula and policy for the general vocational program. The plan was to be implemented by June, 1995.

1.2.12 The General Assembly replace expired federal grant monies to continue the DRS Personal Assistance Pilot Project with general fund dollars in FY 1993. The Commission further recommends that the Personal Assistance Services Pilot Project document the cost effectiveness of such services. (p. 54)

The General Assembly replaced grant funds with state general funds of $268,000 for FY 1993. Cost effectiveness has been documented and submitted with each budget amendment.

1.2.13 Permanent establishment of the Personal Assistance Services Program and its expansion statewide in FY 1994. Expansion will also enable services to be available as appropriate to individuals of all ages. The Commission recommends that consumers in this program participate financially to the extent possible, considering individual financial circumstances. (p. 54)

The Personal Assistance Services Program became a statewide program in FY 1994. There are no restrictions based on age. Services are "mean tested" and many factors are used to determine cost share. In many cases, working people are able to participate on a sliding scale.

1.2.14 A consumer service fund be established to fund unique or specialized multi-agency service packages for individual applicants who need extraordinary services beyond the scope/capacity of local service agencies. Interagency service commitments and performance standards for all involved agencies are prerequisites to obtaining funds as well as documentation of need. Specific criteria for accessing this fund shall be established by the Disability Services Council with DRS serving as the Administering agency for the fund. Requests will be screened by staff of DRS. This fund will provide funding for service gaps which are currently unavailable through existing programs, such as assistive technology, respite care, cognitive therapy, etc. Case managers or service providers apply to the fund with documentation supporting that no other funds are available for the particular request. A means test is to be applied for each participant. This fund is intended to be a "fund of last resort." (p. 65)

DRS established a Consumer Service Fund in FY 1994. This fund of last resort is assessed by case managers or service providers on behalf of consumers who need to overcome funding or eligibility barriers. A number of different services are accessed through the Consumer Service Fund, including respite care, assistive technology, special equipment or supplies, and home or vehicle modifications. The fund served 91 people the first year with an average award of $5,000 each. A six member interagency and consumer panel reviews all applications submitted for funding.

1.2.15 WWRC expand their programs for individuals with brain injuries, regardless of cause of injury, which are: available throughout the rehabilitation continuum from acute phase to community re-entry, are responsive to their physical and sensory needs, and addresses inappropriate behaviors. A plan for program expansion, including funding requirements, must be submitted to the Secretary of HHR by June 30, 1993, for implementation in the 1994-96 biennium. (p. 65)

A Brain Injury Services Expansion Study was completed in 1993. As a result of the 1994 budget amendments, WWRC did receive $150,000 for programming in 1995. Eligibility for the WWRC Head Trauma Program have not yet been expanded for the traumatic brain injury population to include individuals with non-traumatic injuries such as anoxia, toxic exposure, etc.

RECOMMENDATIONS DIRECTED TO THE DEPARTMENT OF MEDICAL ASSISTANCE SERVICES (DMAS)

1.3.1 DMAS complete a study on the cost of providing hearing aids for Medicaid recipients by May 1, 1992, and report to the Secretary HHR, with a phased-in implementation beginning July 1, 1993. Implementation of this program will require new General Fund dollars in FY 94. (p. 12)

The study was completed. DMAS currently reimburses for hearing aids for children. The reimbursement for hearing aids for any Medicaid recipient over the age of 21 does represent a need for $4.1 million additional General Fund dollars in FY 1996.

RECOMMENDATIONS DIRECTED TO THE DEPARTMENT FOR THE DEAF AND HARD OF HEARING (VDHH)

1.4.1 Funding be allocated to DDHH to provide assistance, initially to state agencies and expanding to local public agencies and non-profit organizations, for the provision of real-time captioning during public meetings, as needed. (p. 17)

Although no state dollars have been appropriated for real-time captioning, VDDHH responded to customer demand and used existing technology to assemble computer assisted note-taking (CAN) systems to provide communication accessibility for designated public meetings. Although CAN systems cannot provide the speed or exactness of real-time captioning, they are far less expensive than real-time captioning equipment and consumer response has been consistently positive. As of November, 1994, VDDHH has 6 CAN systems available for loan.

1.4.2 Funding be allocated to DDHH to expand the provision of individual interpreter services based upon increased demand. These services will be available to deaf, hard of hearing, speech impaired, and deaf-blind consumers. (p. 17)

Since 1992, VDDHH has moved away from compensation for all interpreter requests to payment for only those assignments not covered by federal law or state regulation. While the need for additional appropriations for interpreter services has not met original Commission projections, the demand for qualified interpreters has skyrocketed. Unfortunately, the supply of qualified interpreters does not exist. This insufficient pool of interpreters is a direct result of the limited training opportunities offered in the Commonwealth.

1.4.3 Code amendments be introduced which would protect all users of interpreting service and of the statewide telecommunications relay service (TRS). (p. 17)

Code amendments were introduced to and passed by the 1992 General Assembly which protect all users of interpreting services and of the statewide telecommunications relay service.

1.4.4 Code amendments be introduced to establish a codified definition of "Qualified Interpreter", which would assist in protecting consumers of sign language interpreting services in the Commonwealth. (p. 17)

Code amendments were introduced to and passed by the 1992 General Assembly which established a codified definition of "qualified interpreter", which assists in protecting consumers of sign language interpreting services in the Commonwealth.

RECOMMENDATIONS DIRECTED TO THE DEPARTMENT FOR THE VISUALLY HANDICAPPED (DVH)

1.5.1 Funding be allocated to DVH to meet the increased demand for conversion of printed materials to tape or braille as required by the ADA. (p. 17)

DVH established in 1992 the Alternative Media Service which provides material in braille and on audio cassette tape for a fee. In October, 1994, DVH developed a Print Accessibility Plan which outlines how it will provide material to its customers and blind staff in their preferred medium (braille, large print, audio cassette.

1.5.2 DVH develop funding proposals which will address the loss of federal funds for independent living services for the elderly, blind individuals which has been funded through a federal discretionary independent living grant. Such proposals should be submitted to the Secretary of HHR by April, 1992. (p. 36)

DVH has been unsuccessful in obtaining state funds to address the loss of the federal older blind independent living grant, but a 5 year federal grant, which became effective on 10/1/94, will be used to address the independent living needs of this population.

1.5.3 DVH investigate the feasibility of adjusting the current blind registry in order to develop a deaf-blind registry. This study should include the fiscal impact of this system and make recommendations to the Secretary of HHR by June, 1993. (p. 65)

The study has been conducted and reported. The deafblind tracking system developed by DVH is currently in use.

RECOMMENDATIONS DIRECTED TO THE DEPARTMENT OF MENTAL HEALTH, MENTAL RETARDATION, & SUBSTANCE ABUSE SERVICES (DMHMRSAS)

1.6.1 DMHMRSAS and the CSBs will provide on-going training and technical assistance so that mental health personnel are more responsive to the counseling needs of persons with physical and sensory disabilities and their family members. DMHMRSAS is to identify funding for this training in its Eight Year State Plan.

DMHMRSAS currently funds community-based specialized mental health services in five communities of Virginia for people who are deaf or deaf-blind. In its Comprehensive State Plans (1992-2000 and 1994-2000), initiatives that would expand mental health services for deaf and deaf-blind individuals were included, but not funded. Additionally, the Department submitted two applications for federal funding to establish a certificate program within the Community College system to train community and facility mental health service providers to work with people who are deaf or hard of hearing. These proposals were not funded.

RECOMMENDATIONS DIRECTED TO THE DEPARTMENT FOR RIGHTS OF VIRGINIANS WITH DISABILITIES (DRVD)

1.7.1 DRVD conduct training for medical response and law enforcement personnel on identifying and assisting persons with epilepsy. (p. 69)

DRVD has not taken action on this activity primarily due to the lack of agency expertise in this specialized area. Private, non-profit organizations, such as the Epilepsy Foundation can provide the requisite expertise necessary to assist in such training.

RECOMMENDATIONS DIRECTED TO THE DEPARTMENT FOR THE AGING (VDA)

1.8.1 Legislation be introduced in the 1992 General Assembly which provides legal sanctions against actions of abuse and neglect on persons who are elderly or disabled. (p. 20)

The 1992 General Assembly passed Senate Bill 4 which amended the Code related to abuse and neglect of aged and incapacitated adults. The bill made it a misdemeanor to abuse and neglect and prohibited persons in a caretaker role from neglecting an incapacitated person of any age in their charge.

1.8.2 Specialized Transportation Council. Establishment in statute of a Specialized Transportation Council, appointed by the Governor, to guide regional coordination for specialized transportation services. Membership should include the Secretary of HHR and the Secretary of Transportation, a rural and an urban provider, two consumers, and one at-large member. The Council should assist Planning District Commissions or local governments in developing regional coordinated transportation plans and set standards for safe and efficient provision of services by the provider(s) designated in the regional plans. Designated transportation providers should meet certification standards set by the Council. State human service agencies and VDOT should pay for one FTE to staff the Council ($45,000). Operating expenses ($15,000) of the Council should come from a General Fund appropriation. (p. 72)

The Specialized Transportation Council was created in statute in 1992, with the composition that was recommended by the Disability Services Commission. The Council has pursued its mission to develop locally-based coordinated transportation. No General Fund appropriation was made for the expenses of the Council and a full-time employee to staff the Council was not authorized.

1.8.3 A Transportation Incentive fund should be appropriated annually to be used by the Council to facilitate local coordination and planning and fund local demonstration projects. The first year appropriation should be dedicated to funding the implementation of coordinated planning in planning districts. (p. 73)

The Transportation Incentive Fund was established but not funded. To provide it with funds to develop coordinated transportation, the Department for the Aging voluntarily transfers its revenue from the state income tax check-off for elderly and disabled transportation.

RECOMMENDATIONS DIRECTED TO THE DEPARTMENT OF EDUCATION (DOE)

2.1.1 DOE will develop guidelines to facilitate the re-entry of children with traumatic brain injury into the educational system. Transition from medical facilities, evaluation, and instructional programming will be addressed. (p. 22)

2.1.2 The revised School Entrance Physical and Immunization Certificate be used by Child Study Committees within the local school divisions to review medical background in assessing programs for students referred as needing assistance in the classrooms. (p. 22)

2.1.3 The State Board of Education conduct a study of the adult service needs of students with disabilities who are exiting special education. This study should include representation from families of youth with disabilities. Included in the recommendations should be a targeting of youth with disabilities who have vocational potential and individuals who may need long term rehabilitation services. In addition, the study should provide direction for transition planning for students enrolled in special education. The Board of Education should be directed to report its findings and recommendations to the House Education Committee, the House Health, Welfare and Institutes Committee, and the Senate Health and Education Committee by October 1, 1992, for action by the 1993 General Assembly. (p. 22)

2.1.4 State agencies which operate registry systems identifying persons with physical and sensory disabilities develop procedures to ensure the referral of students to the local education agency to determine if the student is eligible for special education services. Such procedures will be completed by July 1, 1991, and transmitted to the DOE. (p. 23)

2.1.5 DOE will maintain funding to support special education personnel preparation (scholarships, loans, retraining institutes) to assist in the assurance that a pool of qualified educators and support staff is available. The Secretary of Education and Council of Higher Education will support development and maintenance of training programs in the areas of physical and sensory disabilities at institutions of higher education in Virginia. (p. 68)

RECOMMENDATIONS DIRECTED TO THE DEPARTMENT OF PERSONNEL AND TRAINING (DPT)

3.1.1 DPT to study the feasibility and make recommendations to the Governor concerning a special appointment system for people with disabilities modeled after the federal Schedule A appointments system. The system should include a provision to hire persons who have completed the special appointments through an internal recruitment. (p. 29)

RECOMMENDATIONS DIRECTED TO THE VIRGINIA HOUSING DEVELOPMENT AUTHORITY / DEPARTMENT OF HOUSING AND COMMUNITY DEVELOPMENT (VHDA/DHCD)

4.1.1 The VHDA and the Department of Housing and Community Development (DHCD) will continue to promote access to affordable, barrier-free housing. Expansion of their programs for specialized housing should be considered in subsequent bienniums. (p. 33)

VHDA promotes affordable, barrier-free housing through all its programs. The agency encourages home modifications through its home improvements program, offers financing for rental and homeownership dwellings, promotes homeownership counseling, trains homeownership counselors and potential home buyers, and continues to evaluate and to develop programs for individuals with special needs.

All of DHCD's housing and community development programs adhere to the requirements and standards of the Americans with Disabilities Act and the Fair Housing Act. In addition, there are several affordable housing programs administered by DHCD specially targeted to persons with special needs including persons with physical and sensory disabilities. An additional objective was established in 1994 in the Community Development Block Grant program that encourages the creation of community service facilities for protected populations, such as people with physical and sensory disabilities. DHCD's Division of Building Regulations provides training programs on the technical and administrative aspects of the ADA and the Fair Housing Act. The State Building Code Office has also been monitoring the National Building Code Standards and providing input to develop more user friendly but comparable standards.

4.1.2 VHDA and DHCD should increase their efforts in public awareness to ensure that persons with physical and sensory disabilities and agencies which serve them are aware of the housing resources which are available to these individuals. (p. 33)

VHDA promotes all its programs by targeting special interests groups, participating on interagency committees and councils, conducting speaking engagements, through mailings, and other public relations efforts. There are also special telephone lines for the hard of hearing.

In all its Divisions and programs, DHCD provides technical assistance and guidance to building owners, developers, project sponsors and consumers to promote public awareness about the needs of persons with physical and sensory disabilities. The development of the state's 1994-97 Comprehensive Housing Affordability Strategy is an example of an extensive public participation process undertaken by DHCD to obtain input from Virginia Citizens and providers about their needs. Strategies and plans of action have been developed to address a priority area related to expanding the housing stock available for persons with special needs.

RECOMMENDATIONS THAT INVOLVE MULTIPLE SECRETARIATS

5.1.1 The Secretary of Education, the Secretary of HHR, the State Council on Higher Education and the Virginia Community College System develop a proposal for the creation of a university consortium such as a Commonwealth Center, to address training for service providers, research, and technology transfer in the area of physical and sensory disabilities for purposes of promoting prevention and early intervention. Such proposal will be presented to the 1992 General Assembly for action. (p. 20)

5.1.2 The Secretary of HHR and the Secretary of Education with the assistance of DPT will conduct an expanded needs assessment for personnel development in the delivery of services to people with physical and sensory disabilities. This needs assessment should be shared with the State Council of Higher Education. The Secretaries, DPT, and the Council on Higher Education should work cooperatively to develop or to contract for the needed pre-service and continuing education programs throughout the Commonwealth. (p. 69)

5.1.3 The Secretary of HHR and the Secretary of Education will direct DMHMRSAS, DRS, DDHH, DVH, and DOE to implement an interagency agreement for providing on-going information and training about counseling disabled individuals and their family members to their local counterparts by July 1, 1993. (p. 69)

RECOMMENDATIONS THAT INVOLVE MULTIPLE AGENCIES

6.1.1 DRS and DVH provide the maximum flexibility in their interpretation of federal eligibility requirements and other program regulations in order to address the needs of persons with physical and sensory disabilities in the Commonwealth. (p.25)

DRS's eligibility requirements for vocational rehabilitation services have become more inclusive for people with physical and sensory disabilities as a result of the 1992 amendments in the reauthorized Rehabilitation Act. All individuals are now presumed to be able to benefit from vocational services. This opens the door to vocational services for persons with much more severe disabilities than had

previously been served by DRS. All programs administered by DRS, which are solely state funded, assure access to individuals of all ages.

The Vocational Rehabilitation program of DVH has an inclusive, rather than exclusive, approach to determining an applicant's eligibility of services, insofar as the federal VR law and regulations allow.

6.1.2 DRS and DVH work to expand vocational training opportunities to increase the earning potential of persons with physical and sensory disabilities. DRS and DVH will explore the feasibility of broadening their interpretations of federal rules and regulations to allow greater access to vocational training by individuals with severe, long-term disabilities. DRS and DVH will report their efforts to the Secretary of HHR no later than July 1, 1993. DRS and DVH will provide case management services to individuals eligible for vocational rehabilitation services. (p. 28)

With the 1992 Amendments to the Rehabilitation Act, individuals, including those with the most severe disabilities are presumed to be able to benefit from vocational services. This has allowed greater access to all services than what had been previous. A formal report regarding DRS's efforts in this area has not been made to the Secretary of Health and Human Resources. DRS is not funded at a level to provide true case management services to all clients who have physical and sensory disabilities. DRS does, though, provide vocational rehabilitation based on an individualized written rehabilitation plan which involves the components necessary to meet the individual's vocational goals.

The staff of DVH are constantly alert to the needs and possibilities for vocational training where needed to assist a consumer achieve his/her vocational goal. For many years, DVH staff have served as resources and advocates in the area of provision of instructional methods, equipment, and materials in ways conducive to access by blind or severely visually impaired trainees. DVH offers consultation to providers/vendors of vocational training services regarding program accessibility and equipment and materials modification.

6.1.3 DRS, DVH, DRVD, DDHH, DOH, GETD, and DOE should conduct local forums annually to solicit input and feedback from present clients and former clients of the agency for the purpose of assessing the efficiency and effectiveness of service delivery systems. (p. 61)

DRS has developed a consumer satisfaction system which combines the results from a specially designed survey instrument with other available data from DRS consumers, including focus groups. With this design, the system measures satisfaction both during the service delivery and after.

DRVD, on an annual basis, conducts public hearings at various locations in every region of the state. Also, has a "Client Satisfaction Survey" used to solicit feedback from clients of the agency, and periodically conducts in-depth surveys of past and current clients and others in the disability community.

VDDHH did not hold local forums between January 1992 and November 1994 due to the absence of a duly-appointed agency head. Nine local forums were scheduled and held in November and December 1994. As of November, 1994, VDDHH was in the process of completing a strategic plan which includes multiply strategies for soliciting consumer feedback.

The GETD has and continues to sponsor and facilitate an annual Jobs Training Partnership Act (JTPA) Equal Opportunity Workshop designed for state and service delivery area level staff with responsibilities for equal opportunity in the JTPA system.

DVH holds such forums annually in the form of public meetings designed to gather input on the annual Vocational Rehabilitation State Plan. Also, DVH, DRS and the State Independent Living Council convene public meetings to gather input on the annual State Plan for Independent Living.

6.1.4 DRS, DVH, DRVD, DDHH, DOH, GETD, and DOE should make maximum use of advisory committees comprised of persons with disabilities, their families, or guardians, as appropriate, in the planning, implementation, and evaluation of services and programs for disabled persons. (p. 62)

DRS utilizes a variety of consumer and other stakeholder committees to assist in planning and development activities. Although agency policy in this area does not exist, DRS uses advisory committees which include persons with disabilities and their families to effect service and program enhancements. The State Rehabilitation Advisory Council, whose primary purpose is to provide the agency with advice and input, is currently developing procedures which will guide input.

DRVD has one current advisory group, the Protection and Advocacy for Individuals with Mental Illness Council, which fulfills a federal requirement. Director of DRVD participates on the Virginia Board for People with Disabilities.

The VDDHH Advisory Board provided important consumer input and guidance to the agency when the Director's position was unfilled. Additional consumer perspectives have been sought through the Interpreter Programs Advisory Committee (a standing committee of the Board) and focus groups.

Parents of children with disabilities were included on the Task force for the Development of a Statewide Comprehensive Needs Assessment for Children,

Adolescents, and Children with Special Health Care Needs. This ad-hoc task force assisted in developing a detailed needs assessment relative to the Maternal and Child Health Block Grant application and included development of a telephone survey used to identify gaps in health care services to children. DOH also notes that a parent is on its Hemophilia Advisory Board.

Within the auspices of the GETD, local private Industry Councils (policy boards) and the Governor's job Training Coordinating Council (advisory Board) are comprised of representatives of agencies that provide services to individuals with disabilities. As part of the development of the Governor's Coordination and Special Services Plan, the GETD solicits comments on the plan from DRS, VBPD and VDDHH.

DVH utilizes a number of advisory committees whose composition includes persons with disabilities and/or family members.

6.1.5 DRS, DVH, DRVD, DDHH, DOH, GETD, and DOE should assure that service delivery units establish and maintain written policies and standards covering the scope and nature of all services provided and the conditions, criteria, and procedures under which each service is available. (p. 62)

DRS maintains written policies and procedures covering the scope and nature of services provided under the vocational rehabilitation program. Review and revision of policy and procedural guidance governing VR services is ongoing. Other DRS programs, for example Personal Assistance Services and Long-Term Rehabilitation Case Management, have their own policies and procedures.

Except for activities funded under the Virginians with Disabilities Act, the eligibility criteria for DRVD's services are set forth in federal statute and regulations. These criteria are incorporated into DRVD's written policies and procedures, which are updated on a regular basis.

The VDDHH Policies and Procedures manual was completely updated in December 1993 and includes specific conditions, criteria, and procedures under which the direct services of the agency are available.

The DOH regulation, "State Plan for the Provision of Children's Specialty Services," contains the policies, standards, conditions and criteria for the provision of Children's Specialty Services and Child Development Services Programs. Each program also has a procedures manual to match the above policies.

GETD requires service delivery areas and other JTPA service providers to establish policies and procedures describing the treatment of individuals with disabilities who apply for employment or participation, provisions for integrated programs to the

maximum extent appropriate, requirements for reasonable accommodation and auxiliary aids and services, and provisions for review systems regarding site selection to ensure accessibility. GETD's policy also establishes specific requirements regarding employment practices and employment-related training program participation.

All DVH programs have manuals which cover policies and standards. In addition, the performance plans for DVH direct service staff contain certain service delivery standards.

6.1.6 DRS, DVH, DRVD, DDHH, DOH, GETD, and DOE should assure that an individualized written program of services is jointly developed with persons with disabilities or their parent, guardian, or other representative, as appropriate. The state agencies should assure that the individualized written programs are fully implemented. The individualized written program should be monitored, evaluated, and updated periodically, as appropriate. (p. 62)

All DRS clients have an individualized written rehabilitation program (IWRP) which is jointly developed by the consumer, his/her family, a representative, and the DRS counselor. Consumer IWRPs are reviewed and updated at least annually and more often if necessary. All revisions to a consumer's IWRP are jointly developed and require the consumer's and/or their representative's signature.

The activities of one of DRVD's federally funded projects, the Protection and Advocacy for Individual Rights, requires a formalized written service plan developed jointly with clients. it is more typical that client contact is primarily by phone and does not require or lend itself to the development of formal service plans.

The nature of VDDHH services is such that written programs are not practical. Typical services involve a singe event contact. Long range client planning is not currently in the VDDHH array of services.

Children's Specialty Services and Child Development Services of DOH have written care plans that are developed and discussed with the patient and family. Each program also has case managers that implement, monitor, evaluate, and update the plans periodically.

GETD reports that the Job Training Partnership Act requires that each service delivery area complete an objective assessment and develop an individual service strategy (ISS) for each participant enrolled in the year-round youth and adult programs for the economically disadvantaged.

All service components of DVH have individualized service programs.

6.1.7 DRS, DVH, DRVD, DDHH, DOH, GETD, and DOE should assure that services are provided by individuals licensed or certified in accordance with state licensure laws or regulations. (p. 62)

DRS is in compliance with all laws and regulations that involve special certifications.

With the exception of its attorneys, who are required to be admitted to and maintain licensure with the Virginia State Bar, DRVD does not employ the type of professionals who are subject to certification or licensure by the various health regulatory and professional boards.

Interpreters are the only service providers in the VDDHH service delivery system for whom licensure or certification is available and VDDHH will contract only with certified or state-screened interpreters. In addition, staff who provide interpreting services are required to have state screening or national certification.

Licensure of DOH staff is assured at the time of hiring and at license renewal time. State licensure laws and regulations are followed.

For individuals in need of interpreter services, GETD requires that the "Directory of Qualified Interpreters for the Deaf and Hard of Hearing" be used to obtain these services.

The DVH Vocational Rehabilitation Program uses approved vendors listed in the DRS Services and Facilities Manual. Where applicable, appropriate licensure or certification is part of the screening process for prospective vendors. DVH only purchases interpreting services for its deafblind customers from individuals certified by the National Registry of Interpreters for the Deaf. Psychological and professional counseling services are purchased from only certified or licensed individuals. Eye doctors who serve under contract as low vision examiners must submit copies of their licenses to DVH.

6.1.8 DRS, DVH, DRVD, DDHH, DOH, GETD, and DOE should conduct annually a cost-benefit evaluation of programs to assess efficiency and effectiveness of services being delivered to persons with disabilities. (p. 62)

DRS has not fully met this recommendation for all of its programs. DRS administers a variety of state and federal funded programs that require cost-benefit analysis tailored to the uniqueness of each program. Some programs lend themselves to a cost-benefit analysis, whereas other programs, may have more qualitative characteristics than quantitative. For the federally funded vocational rehabilitation program, DRS utilizes a variety of efficiency and effectiveness measures to monitor case service expenditures for clients and outcome rates. Additionally, DRS closely reviews the number of successful closures per year, as well

as the percentage of persons rehabilitated who have severe and most severe disabilities, and the timelines of service delivery.

As of the end of 1994, DRVD had not employed any cost-benefit evaluations of the services it provides to people with disabilities.

VDDHH completed a cost-benefit analysis of all agency programs and services in June 1994 and plans on continuing to do this on an annual basis.

Cost-benefit evaluation is part of DOH's Children's Specialty Services data collection and is reported annually in a report that includes a cost analysis of services provided. Continuous analysis is completed throughout the year for medications, hospitalizations, ancillary services, contractual services and supply costs. The Child Development Program is currently being studied.

GETD does not conduct annual cost-benefit evaluations of programs because of cost constraints and staff limitations. However, GETD does conduct statewide and target group evaluations biennially.

DVH has conducted annual cost-benefit evaluations since 1990 in order to improve services and customer outcomes.

6.1.9 A legislative resolution be introduced in the 1992 General Assembly directing DDHH in coordination with DVH, DOH and other appropriate agencies to study and enhance the current level of awareness and preparedness of emergency response personnel to deal with critical situations involving persons who are deaf, hard of hearing, speech impaired, deaf-blind and visually impaired. (p. 69)

House Joint Resolution 2 (1992) and House Joint Resolution 461 (1993) were approved by the General Assembly and the studies were completed. House Document 46 and House Document 99 provide the results of these studies, which included the development of best practices guides and other materials of use to emergency service providers.

DOH's Office of EMS routinely offers classes at its annual symposium addressing the principle of serving persons with disabilities. All basic Emergency Medical Technicians are taught principles of dealing with critical situations involving persons with disabilities.

DVH participated during a two year period on an interagency task force which surveyed the needs, developed materials in various media, developed an implementation plan and operated a pilot project. The emergency response preparedness program (Project HELPS) was implemented statewide in September, 1993.

6.1.10 The Superintendent of Public Instruction and the Commissioner of DOH cooperatively revise the <u>School Entrance Physical and Immunization Certificate</u>. Details regarding a history of otitis media and results of hearing evaluation shall be included. The revised form shall be printed and disseminated to school divisions prior to the 1991-92 school year. The <u>Health Manual for Schools</u> should also be revised to ensure that school personnel are apprised of the value of the information and provided guidance regarding using medical information in the educational planning for students. (p. 22)

In 1992, the Committee on School Health Standards, whose membership included representatives of the Virginia Departments of Education and Health, local school divisions, local health departments, and the Virginia Pediatric Society, completed revisions of the preschool form entitled, "School Health Entrance Physical and Immunization Certificate" and the school health bulletin, <u>Health Manual for Schools</u>. Revisions to the "School Health Entrance..." form included recommendations of the Disability Services Commission regarding a history of otitis media and results of hearing evaluations. Revisions to the school health manual were extensive and included recommendations regarding apprising school personnel of the value of the health information and providing guidance about using medical information in educational planning for students.

6.1.11 VDOT and Department for the Aging develop a program to recruit, train and coordinate a statewide corps of trained volunteer drivers to provide transportation to persons with physical and sensory disabilities, the elderly, and other persons who are transportation disadvantaged. (p. 73)

A resolution requesting VDOT and the Department for the Aging to train volunteer drivers was not introduced.

6.1.12 Cooperative agreements will be developed between the Center for Innovative Technology (CIT) and DRS, DVH, and DDHH for the purpose of promoting the development of assistive technology to promote self-sufficiency and employability of individuals with physical and sensory disabilities. Such agreements will by executed by July 1, 1992. (p. 12)

In the 1993 General Assembly, HJR 697 stipulated that cooperative agreements be signed. Since that time, CIT made contact with the Virginia Assistive Technology System (VATS), which is within DRS, and has worked cooperatively with VATS to achieve this goal. The agreement was signed and was in place by March 1, 1994. CIT initiated the formation of a Virginia Assistive Technology Business Roundtable which met initially on November 22, 1994.

RECOMMENDATIONS FOR NON-SPECIFIC AGENCIES

7.1.1 The Governor is requested to require all state agencies to follow federal and state regulations and policies regarding provision of interpreter services as required by the ADA; the cost of providing interpreter services will be borne by each agency. (p. 17)

VDDHH reports that Executive Memorandum 3-92 which offered draft policies and procedures for the provision of interpreting services for use by all state agencies expired on June 30, 1994. VDDHH determined, through discussions with the Office of the Attorney General, that other state agencies could piggyback on the VDDHH Interpreter Services contract, thus taking advantage of contracted rates for service. As of November 15, 1994, 5 agencies had opted to do this.

7.1.2 The following issues be forwarded to the Commission on Health Care for All Virginians:

- the availability and affordability of Health Insurance for persons with physical and sensory disabilities (waiting periods, eligibility barriers, costs, and insufficient coverage), and
- availability and cost of health related services for specific and unique medical needs of persons with physical and sensory disabilities. (p. 31)

7.1.3 Virginia develop a plan for providing medical services to persons with physical and sensory disabilities which are affordable and accessible. (p. 31)

7.1.4 The Joint Board Liaison Committee (JBLC) consider the possibility of expanding its membership to include the Boards of DDHH and DVH. The JBLC should prepare and distribute to local governments and local and state service agencies an annual report highlighting its accomplishments in promoting effective interagency coordination among the participating agencies and identifying policy areas which require additional study by the JBLC. (p. 45)

The last meeting of the Joint Board Liaison Committee (JBLC) was in December, 1993. The above recommendation of the Disability Commission was not implemented. The JBLC formally disbanded in November, 1994.

7.1.5 The proposed new State Library for the Visually and Physically Handicapped receive top priority in funding for capital outlay projects. (p. 17)

The State Library for the Visually and Physically Handicapped was constructed using Virginia Public Building Authority (VPBA) funding. The Department of Planning and Budget (DPB) developed supporting information for the VPBA funding proposal.

DVH reports that the library was occupied in July 1994.

7.1.6 All state funded programs for persons with physical and sensory disabilities develop eligibility criteria which provide the maximum access and consistency of terms. The new programs proposed by this Commission must place special emphasis on ensuring that program regulations do not constitute a barrier to access to the services. (p. 26)

All programs administered by DRS are solely state funded, assure access to all ages of individuals, and most are limited to specific disability groups. There has been concern expressed that some of the new programs only serve people with physical and sensory disabilities, and the these services may not be available in the larger system for people with other disabilities, ie. mental health, mental retardation, and substance abuse.

Most programs of VDDHH do not have specific eligibility criteria. The Technology Assistance Program eligibility standards were recently revised to adjust the income eligibility factors to allow a greater number of individuals to benefit from the program.

DVH supports maximum access and consistency of terms across state-funded programs for persons with physical and sensory disabilities, to the extent possible.

7.1.7 A proposal for a mandated <u>option</u> for insurance coverage of physical rehabilitation services be reviewed by the Special Advisory Commission on Mandated Benefits and forwarded to the 1992 General Assembly for action. (p. 38)

In 1993, DVH conducted and reported the results of a study on insurance coverage of visual rehabilitation services. Although not directly involved, DVH staff are aware that advocates for third-party payments of visual rehabilitation services attempted twice unsuccessfully to expand third-party payment coverage in Virginia.

7.1.8 A joint resolution was adopted by the Commission requesting a joint legislative study on the Second Injury Fund. Recommendations will be submitted to the 1992 General Assembly. (p. 38)

7.1.9 Local agencies serving persons with physical and sensory disabilities develop and annually update substantive and enforceable interagency cooperative agreements. As part of the annual update process, participating agencies should assess the effectiveness of the agreement in addressing interagency service needs as well as their agencies' compliance with agreement provisions. Such agreements will be reviewed by local planning boards. (p. 44)

The Department of Education (DOE) reports that participating agencies do assess the effectiveness of interagency cooperative agreements. As an example, DOE works with the lead agency, DMHMRSAS, to administer Part H of the Individuals with Disabilities Act (IDEA) for infants, toddlers and preschoolers. Local interagency coordinating councils are required as part of their application for funds, to include types of services and eligibility criteria. The interagency council at the state level is studying and developing appropriate monitoring options for determining compliance and effectiveness. In addition DOE and DRS, through Project Unite are implementing models for local cooperative agreements for students' transition from school to post-school experiences. The project is evaluating the effectiveness of the programs by field-testing at 21 sites across the Commonwealth.

VDDHH participates in local agreements with early intervention agencies for services for infants and toddlers. Additional interagency agreements include those with the Virginia Schools for the Deaf and the Blind, the Lake Area Agency on Aging, the Northern Virginia Resource Center for Deaf and Hard of Hearing Persons, and the Communication Center for the Deaf (Richmond) for the provision of Outreach services locally. Further agreements exist as part of the TAPLOAN program where local agencies serve as TAPLOAN sites to make various assistive devices available for loan at the local level.

7.1.10 Local interagency service teams be established in each local/regional service area to address the needs of individual consumers who require services from more than one agency. Interagency service teams, composed to respond to the needs of the consumer, will by responsible for integrating the array of required services. Membership of these teams will include representatives of local DRS, DVH, DDHH, local Health Department, local social services or welfare department, local school division, community services board and other human resource agencies, as appropriate. These teams shall report to the client's case manager or counselor, as appropriate. (p. 45)

DRS reports that teams have been used in the communities that administer the Personal Assistance Services Programs to facilitate services for a consumer that are needed from more than one agency. These local interagency service teams are informal and not used across all programs or on any standardized or regular level.

DOE reports that interagency teams have been established at the local level to address needs of individual consumers. Given as examples are: the individualized family service plans required by Part H of the Individuals with Disabilities Act which are developed for each child by a multi-disciplinary team including the parents; the use of local interagency coordinating councils to manage services for transitioning students through UNITE; and the local interagency assessment planning teams required under the Comprehensive Services Act which focuses on children at risk for placement outside of the community.

VDDHH Outreach Specialists are available to assist local service providers in meeting the needs of individuals consumers.

DVH participated on an interagency Case Management Work Group which was charged with developing recommendations and a draft legislative packet designed to implement the case manager concept.

7.1.11 All human service agencies include public awareness as an ongoing responsibility in the administration and management of the service system for people with physical and sensory disabilities. Funds should be targeted by these agencies to support public awareness activities. (p. 56)

DRS has a marketing budget that focuses on increasing employment opportunities for people with disabilities. These public awareness activities are staff supported. Additionally, Disability Services Boards promote awareness of physical and sensory disabilities and the ADA in their local communities. These DSBs have been staffed by DRS employees.

Public awareness is an ongoing responsibility in the administration and management of the DOE service system.

In May 1994. local departments of social services (DSS) were provided a listing of 11 public awareness publications related to Early Intervention Services for Infants and Toddlers. These publications were aimed at the traditionally underserved populations in the early intervention system, minorities and those living in rural areas. Approximately 12,500 publications were distributed to local departments of social services requesting them.

VDDHH continues to support public awareness activities through participation in health fairs, deaf awareness activities (including the publication of the Deaf Awareness Week Calendar) and other local and statewide events and opportunities.

The Virginia Department for the Aging (VDA) and Area Agencies on Aging (AAAs) are required by Title III of the Older Americans Act to provide information and referral services to assure reasonably convenient access to services. In addition, AAAs are required to provide outreach efforts that will identify persons eligible for assistance, with special emphasis on, among others, older individuals with severe disabilities. All AAAs provide information and referral services and perform outreach in a variety of ways. many AAAs and VDA have toll-free phone numbers for ease of access.

DVH has developed video tapes and conducted a "Vision Fair" to increase awareness of its services. The agency has not created an on-going budget for public awareness activities, however, staff always seek media coverage of special programs and events.

7.1.12 Each state agency serving persons with disabilities should by required to initiate an assessment of current program evaluation/quality assurance programs for the purpose of formalizing and systematizing those activities. Consumers and consumer groups should be involved in the assessment. (p. 61)

The DRS Policy, Planning and Evaluation Unit performs ongoing assessments of agency programs moving toward an agency-wide evaluation system which supports and enhances all DRS activities. Many DRS programs have consumer advisory groups that participate in the collection and analysis of information.

Assessment of current DOE program evaluation/quality assurance programs occur in a systematic fashion. Virginia's Special Education State Plan includes evaluation activities to assess the effectiveness of special education for students. In addition, the Virginia DOE's federal program monitoring procedures address quality assurance for students with disabilities.

VDDHH collects program evaluations from all participants in the Virginia Quality Assurance Screening and all agency-provided training activities. In addition, the agency is developing a full customer service program which will include specific initiatives for each agency program area. Further development includes a comprehensive review of each program area to ensure that it is providing an effective and appropriate service in light of current customer needs.

VDA currently has a formal, systematized program evaluation/quality assurance program that involves onsite monitoring of Area Agencies on Aging (AAAs) every year and desk monitoring every month. AAAs are required to monitor their subcontractors annually. Input from consumers and consumer groups is obtained through client satisfaction surveys and public hearings for development of Area Plans for Aging Services.

The DVH Commissioner in 1994 has met with at least 40 constituency groups to discuss how to enhance agency services. Also, DVH has sought input from the Advisory Committee on Services and the Vocational Rehabilitation Advisory Council regarding program evaluation.

7.1.13 Each state agency serving persons with disabilities should develop and implement a client satisfaction survey. Consumers and consumer groups should be involved in the development of the instrument. (p. 61)

DRS has developed a consumer satisfaction system which combines the results from a specially designed survey instrument with other available data from DRS consumers, including focus groups. With this design, the system measures

satisfaction both during the service delivery and after. The State Rehabilitation Advisory Council, comprised of over 51% people with disabilities, was involved in the development of the system.

DOE has begun activities to develop client satisfaction surveys.

DMHMRSAS has initiated a number of consumer satisfaction, program evaluation, and public awareness activities, however, its efforts have been focused on persons with mental disabilities and substance abuse problems.

DOH reports that a client satisfaction survey has been developed and implemented in the Child Development Service Program. Children's Specialty Services Program psychologists developed and implemented a survey of their client's. One Children's Specialty Services Clinic developed and implemented a client satisfaction survey.

Client contact with VDA is primarily single-contact by phone which is the reason that client satisfaction surveys are not done. Most Area Agencies on Aging conduct client satisfaction surveys of some kind, and all AAAs conduct annual public hearings at which consumers can voice their opinions or submit them in writing.

In FY 1995, GETD planned to conduct a customer satisfaction survey for the Job Training Partnership Act Title III program (Dislocated Workers) to determine program effectiveness and efficiency. A portion of the survey was to target clients with disabilities.

The DVH Commissioner and management staff have developed a Customer Service Plan which has customer satisfaction surveys and interviews as a component. The Plan was to be implemented by 1/1/95.

7.1.14 Consumers should participate in a client satisfaction survey after completion of their rehabilitation or other programs. Active clients who are presently being served should be sampled, via the satisfaction survey. Results from surveys should be compiled analyzed, and reported to the appropriate Commissioner and the Secretary of HHR. Survey results should be utilized in the overall programmatic evaluation of agency efficiency and effectiveness. (p. 61)

The State Rehabilitation Advisory Council is mandated by federal law to make an annual report to the Governor and to the Commissioner of the federal Rehabilitation Services Administration that specifically includes satisfaction of DRS clients regarding the services they received. This system became operational in the summer of 1994. As of November, 1994, no reports had yet been generated.

7.1.15 A legislative oversight commission should be established in 1998 by resolution to review the progress of programs and funding recommendations and make adjustments for future direction for service delivery systems for persons with physical or sensory disabilities. (p. 63)

7.1.16 Human service transportation providers to also provide public transportation when and where appropriate. (p. 73)

VDA reports that three Area Agencies on Aging provide public transportation with Federal Transportation Administration Section 18 funds (rural public transportation). As of November, 1994, VDA has planned to use any additional Section 18 funding and expand services to Planning District 13 in 1995.

7.1.17 State agencies prohibit the "dumping" of their clients due to the ADA on public transportation systems. (p. 73)

VDA has not viewed the ADA as an opportunity to "dump" clients, but rather has provided incentives through the Area Agencies on Aging to encourage coordination of transportation services for individuals with disabilities and, when possible, to do so without regard to age.

Passage of the ADA has made no appreciable change in the level of transportation services provided by DVH. DVH continues to provide transportation for its customers, where necessary, incidental to the provision of agency services.

7.1.18 Modification of state-controlled regulations and policies that discourage coordination. (p. 73)

VDA encourages coordination with agencies which serve persons with disabilities. Examples of this is through policies affecting in-home services, nutrition services, transportation services, location of services and coordination with programs conducted under the Rehabilitation Act and the Americans with Disabilities Act.

DVH supports this recommendation and seeks coordination with other agencies where feasible.

LD8151761

HOUSE JOINT RESOLUTION NO. 83

Offered January 21, 1994

Requesting the Secretary of Health and Human Resources to evaluate the implementation of the recommendations made by the Commission on the Coordination of the Delivery of Services to Facilitate the Self-Sufficiency and Support of Persons with Physical and Sensory Disabilities.

Patrons—Mayer, Diamonstein, Giesen and Keating

Referred to Committee on Rules

WHEREAS, in 1990 the Commission on the Coordination of the Delivery of Services to Facilitate the Self-Sufficiency and Support of Persons with Physical and Sensory Disabilities was established to address the services, needs, availability of services, costs and quality of services for persons with physical and sensory disabilities; and

WHEREAS, the 1992 Commission Report outlined a 10-year plan of action to design and implement this system of programs and services for persons with physical and sensory disabilities; and

WHEREAS, the 10-year plan of action calls on the Secretary of Health and Human Resources to perform an evaluation of the implementation of Commission recommendations in 1995 and to propose legislation in 1996 to make necessary adjustments in the service delivery system; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Secretary of Health and Human Resources be requested to initiate development of an evaluation plan to critically review the changes made in the service delivery system and the status of implementation activities in response to the recommendations in the 1992 Report of the Commission on the Coordination of the Delivery of Services to Facilitate the Self-Sufficiency and Support of Persons with Physical and Sensory Disabilities.

The Secretary is requested to form a task force comprised of consumers, and representatives of disability services boards and local services providers to assist in planning and conducting this evaluation. The Virginia Board for People with Disabilities is requested to provide staff support for the evaluation. The evaluation plan shall be completed by January 1, 1995.

The evaluation plan shall specify the methodologies to be employed to assess such topics as (i) the effectiveness of the Disabilities Services Council and the disability services boards in the development of community based services and in meeting their statutory responsibilities; (ii) the impact of new funding on the availability of services for persons with physical and sensory disabilities; (iii) the accomplishments and effectiveness of state-level interagency committees that address service issues including the Plan of Cooperation established in the Virginians with Disabilities Act; (iv) the efficiency of existing Information and Referral (I&R) programs in providing an effective point of entry and in meeting the transition and continuing service needs of consumers; and (v) the implementation of Commission recommendations for administrative action by involved state agencies.

The Secretary of Health and Human Resources shall implement this evaluation plan in time to report the resulting findings and recommendations to the Governor and the 1996 General Assembly pursuant to the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.