

June 2011

Assessment of the Disability Services System in Virginia



Virginia Board for People with Disabilities

*The Commonwealth's
Developmental Disabilities Council*

**2011 Assessment
of the
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This report is also available in alternative formats upon request and on the Virginia Board's website.

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Preface

Background: The Virginia Board for People with Disabilities, the Commonwealth's Developmental Disabilities (DD) Council, is pleased to provide its 2011 *Assessment of the Disability Services System in Virginia*, produced in accordance with the *Code of Virginia* (51.5-33 [2]) and the federal *Developmental Disabilities Assistance and Bill of Rights Act* (PL 106-402, 2000). This is the Board's third assessment of the state's disability services system. Previous editions were published in 2006 and 2008. The interval between assessments was lengthened from two to three years by the 2008 General Assembly.

This latest edition features a new chapter largely consolidating coverage of services provided through the Medicaid public insurance program. Medicaid was covered primarily in the Community Supports chapter of previous editions, but other chapters included significant amounts of Medicaid information as well. Coverage of Information and Advocacy Resources has been reformatted and is now contained in an appendix to the assessment.

The Executive Summary of previous editions has been replaced with a new introductory chapter on Key Findings and Board Recommendations. It replaces the previous Areas of Concern and Recommendations sections that previously concluded individual topical chapters and presents the Board's findings and recommendations in a more concise and targeted manner stressing broad-based, system-wide issues. Key developments since the 2008 assessment, recent data trends, and other information specific to each service area are still presented in their respective chapters. This new introductory chapter is also available as a separate document.

Like the previous editions, the 2011 assessment describes disability services and supports that are primarily—but not exclusively—funded, operated, licensed, regulated, or contracted for by state agencies. For each service topic, it details eligibility requirements, how services are accessed and delivered, the types of services available, costs and payment sources, and oversight and quality assurance responsibilities. Each chapter provides longitudinal data showing trends in utilization and expenditures for specific services, as appropriate and available. A reference list that includes key websites concludes each chapter. As requested by readers of previous editions, online links to key reports and programs are also included within the body of each chapter.

Scope and Methodology: To develop its assessment, the Board sought public comment both on changes to and experiences with the system over the past three years and on ways in which this edition could be improved. In March and April of 2010, Board staff conducted six public comment forums across the state. The Board also solicited feedback through its newsletter, website, and e-mail solicitations for a six-week period. This input was compiled and analyzed by the Board to help shape assessment development.

Descriptive information in the assessment was gathered from agency planning and performance reports, task force reports, legislative studies, state and federal laws and regulations, agency policies, state agency and organizational websites, direct communications with their

staffs, and other available sources. Except where noted, this assessment contains 2010 data along with longitudinal data for comparison. State agencies were asked to provide the most current data, but it was not always available. With the exception of the Key Findings and Board Recommendations, drafts of descriptive content were reviewed by agency personnel to verify the accuracy of the information and data presented.

An ad hoc committee of Board members worked with staff to review and consider all public comment as well as descriptive information and data for the assessment in draft form. After thorough consideration and discussion, the committee identified key findings and developed recommendations for system improvements. The results of their deliberations were provided to the full Board for review and comment prior to the completion of the final draft of the assessment. Their decisions regarding the findings and recommendations contained in the assessment are consistent with the values and tenets of the *Developmental Disabilities Assistance and Bill of Rights Act* that requires Developmental Disabilities Councils to engage in activities:

“...which contribute to a coordinated, consumer- and family-centered and directed, comprehensive system of community services, individualized supports, and other forms of assistance that enable individuals with developmental disabilities to exercise self-determination, be independent, be productive, and be integrated and included in all facets of community life.”

This assessment does not address all of the services and programs available to persons with disabilities in Virginia. Pursuant to the Board’s federal requirements, it focuses on individuals with developmental disabilities (DD); however, many of the services addressed affect persons with other disabilities, and the Board’s findings and recommendations are relevant to those populations as well. Services specifically designed for individuals with serious mental illness or substance abuse disorders are not covered since these areas are not part of the Board’s federally authorized mission. This assessment also does not address services for individuals with disabilities who are in juvenile and adult correctional settings. The Board recognizes that other gaps in coverage may be identified, and that despite its best efforts, there may be undetected errors or important issues that have been left unaddressed. Readers are encouraged to bring those oversights to its attention, and efforts will be made to correct them in future editions.

Acknowledgements: The Board would like to express its deep appreciation to all those who contributed to development of its 2011 assessment, which was possible only with the information and cooperation provided by a host of individuals both inside and outside of state government. The Board is especially grateful to the numerous state agency officials and staff who worked with the Board and responded to requests for information, data, and content reviews. Their assistance in clarifying or identifying critical issues and ensuring content accuracy was invaluable. The guidance of individuals with disabilities, advocates, and others who provided public comments—whether in person or by mail, fax, or phone—is greatly appreciated.

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Board Membership, Staff, and Contact Information

I. Key Findings and Board Recommendations

During our lives, most of us will experience some type of disability—either permanent or temporary. As aptly stated by Connie Garner, former Policy Director of the U.S. Senate Health, Education, and Labor Committee, at the 2011 Disability Policy Conference in Washington, D.C., **“None of us knows who we will be tomorrow.”** The average citizen often assumes that a comprehensive system of services and supports is, or will be, in place in the eventuality of a disability.

With that thought in mind, the Commonwealth of Virginia is at a major turning point. The potential exists to transform its services for citizens with intellectual and developmental disabilities; however, it is important to keep in mind that decisions on disability policy and funding are primarily political in nature.

Over the past decade, despite the recent deep economic recession from which the nation and the state are just beginning to recover, Virginia has remained relatively well-off financially. In *Virginia Compared to Other States* (http://jlarc.state.va.us/pubs_rec.htm), the Joint Legislative Audit and Review Commission (JLARC) reports that Virginia has ranked among the top ten states in per capita income since 2004. In contrast, Virginia consistently ranks near the bottom among the states in its level of “fiscal effort” on behalf of services for individuals with intellectual and developmental disabilities (ID/DD). The *State of the States in Developmental Disabilities* (www.cu.edu/ColemanInstitute/stateofthestates), a well-respected annual national study, defines fiscal effort as how much a state spends for both community supports and publicly or privately operated institutional services, excluding nursing facilities, per \$1,000 of total state personal income. Using that measure, it ranked Virginia as 45th in fiscal effort for all ID/DD services during 2004, 2006, and 2009. Virginia’s fiscal effort for community-based ID/DD services alone ranked 46th in both 2004 and 2006, and in 2009, the state ranked 43rd.

The **2011 Assessment of the Disability Services System in Virginia** examines how, or whether, services have changed since the **Virginia Board for People with Disabilities** (referred to hereafter simply as “the Board”) last assessed the system in 2008 and calls attention to the substantial work that still lies ahead. In conducting its assessment, the Board found that numerous positive steps have been taken to serve people better, but some barriers to change remain. Individual chapters cover early intervention, education, employment, Medicaid, community supports, institutional services, health care, community housing, transportation, and emergency preparedness. Each chapter describes positive steps taken to serve individuals better, service gaps, complexities of service access and delivery, and barriers to improvement.

This summary focuses on the broad-based disability services system as a whole. Its key findings draw on information and data supplied by the agencies that provide those services for

individuals with disabilities, and its recommendations address significant service gaps, barriers, or issues. The Board's recommendations target systemic improvements to better support individuals with disabilities across their lifespans. For this summary, selected data is drawn from the individual assessment chapters on various services, but it is not fully repeated, and those chapters should be consulted directly for details including source references. To expedite searches for these details, the full assessment, including all of the chapters listed above and useful appendices, can be found on the Board's website (www.vaboard.org/reports.htm).

As a lens for examining the current service system, the Board developed the ***Benchmarks for Evaluating Public Policy in Virginia*** listed below. The purpose of these benchmarks is "...to inform future policy and strategic investments in community supports and infrastructure that will enable Virginia's citizens with disabilities to return the Commonwealth's investment through increased independence, educational achievement, economic self-sufficiency, and community or civic engagement."

Benchmarks

Individuals with disabilities have access to and receive flexible, person-centered services and supports that:

- ✓ Provide a single point of entry that is not disability specific;
- ✓ Offer choice and maximize personal decision-making;
- ✓ Are available no matter where the individual lives and are effective, timely, and reliable;
- ✓ Promote high expectations and individual potential and strengthen families;
- ✓ Continue as needed across the lifespan; and
- ✓ Have sufficient oversight to ensure health, safety, and welfare and to prevent exploitation, fraud and waste.

In developing these *Benchmarks* and the *2011 Assessment of the Disability Services System in Virginia*, **the Board recommends and advocates for implementation of the following core system features:**

- Publicly funded supports for children and adults with disabilities and their families must be ***front-loaded to provide services as soon as indicated at appropriate levels***, reducing services needed over the individual's lifespan and maximizing the individual's opportunities to "give-back" to the community at large.
- Further, in order to thrive, individuals with disabilities must receive services and supports appropriate to their needs in ***inclusive, integrated community settings*** and not be segregated from their fellow citizens.

- **Accountability for service quality and effectiveness** is essential not only to ensure individual outcomes and safety but also to ensure sound use of taxpayer funds. A commitment to **meaningful, consistent oversight** is therefore required.
 - State leadership should set performance expectations for agencies that include reasonable timeframes and are measurable, realistic, and person-centered, with both positive and negative consequences for those agencies based on their results.
 - Both the performance expectations and outcomes should be published and available on Secretariat and agency web sites.
- To ensure accountability, **state agencies must have the capacity and a mandate for identifying, collecting and analyzing meaningful outcome data for each program or service**. Capacity building involves adequate manpower, staff training, and technology. In conducting research for its assessment, the Board found that state agencies all too often lacked reliable data on even simple measures, such as unduplicated counts of individuals served by a program. Many agency programs have inadequate quality assurance processes in place to ensure that data collected is accurate and timely, and too often, outcome data are not available on agency websites. Some data, even in recent reports and documents, were several years old, and other data were not available for a state fiscal year because they were based on the federal fiscal year. Like the private sector, state agencies need to develop reliable, valid data on both individual outcomes and expenditures. Outcomes should address whether the services that they provided were appropriate, timely, and made a difference in individuals' lives.

In the opinion of the Board, adherence to the *Benchmarks* listed above and the adoption of these core system features when developing or expanding disability services, including their integration into decisions involving **contract services**, can significantly improve community inclusion and integration throughout the Commonwealth. More prudent use of scarce taxpayer funds will also result.

Lifespan supports should begin at initial diagnosis, and ideally, screening for developmental delays or other disabilities should occur as part of routine medical screening as an infant or child ages. Early receipt of needed services at adequate levels can reduce functional impairments later in life, thereby, promoting more self-sufficiency. Despite some recent improvement, available data shows that Virginia still continues to perform poorly and lags behind other states in the **identification of infants and toddlers needing early intervention services** (also known as “Part C services”) from birth to age three, especially in the first year of life. Since 2005, Part C improvement plans have called for Virginia to contact states serving a high percentage of children from birth to age one to determine those states' effective outreach practices, but this has still not been completed.

The Board's 2006 assessment addressed this issue, and it is still a concern. This lack of early identification was also cited by JLARC's 2009 *Assessment of Services for Virginians with Autism Spectrum Disorders*. The Commonwealth's poor performance in early identification and

concurrent barriers to accessing early intervention, such as local variability in the scope and availability of services and the cost of providing intense intervention at very early ages, mean that more intensive services will be needed for children to “make up for lost time.”

The number of children identified through the Part C early intervention system has also been disproportionate to the significant amount of money that has been infused into that system. Between state fiscal years (SFYs) 2006 and 2009, general fund appropriations to the Part C system more than doubled, from \$3,125,000 to \$6,861,000. From SFYs 2006 to 2010, however, the “Annualized Count” of eligible children entering the Part C system increased only by 31.4 percent, from 10,212 to 13,421. The Department of Behavioral Health and Developmental Services (DBHDS) has long recognized the need to better review Part C expenditures to determine whether sufficient funds are being directed to early intervention Child Find efforts, but that determination has not occurred, and the reasons for lack of review are unknown.

The percentage of children with disabilities enrolled in Head Start under a Part C Individual and Family Services Plan declined from 15 percent in federal fiscal year (FFY) 2008 to nine percent in FFY 2010. No explanation is available for this decline, but analysis would be useful to determine if more of these children are being served in the Part C system as opposed to Head Start. Child Find, however, was not addressed in the *Report on Virginia’s Part C Early Intervention System* submitted to the General Assembly by DBHDS in 2010.

Positive developments in early intervention have occurred since the 2008 fiscal year. After three years of being in the “needs assistance” category, Virginia’s program was found to meet federal requirements. The newly established **Medicaid Early Intervention Program** provides an important funding source for early intervention services that increases revenue to the system, facilitates access to needed interventions, and improves provider rates, which could lead to improvement in the number and quality of available providers. The federal *American Recovery and Reinvestment Act* (ARRA) has also provided new funding for the system over the past two years, but the end of this funding on September 30, 2011, is likely to affect fiscal stability.

As is the case with the disability services system as a whole, obtaining accurate data and tracking monies spent by service or program have been challenges for Virginia’s early intervention system. Some improvements to program, revenue, and expenditure reporting requirements, however, have been made, such as no longer allowing aggregate expenditure reporting by localities that cannot be tracked to specific services. Nonetheless, comparisons of **Infant and Toddler Tracking System** data over time to determine statewide trends continue to be difficult due to ever-changing reporting requirements and formats. DBHDS has also expressed concerns about the reliability of the local data that it receives and, as a result, the ability to accurately determine funding allotments that localities should receive. Ongoing review of changes in expenditures for certain service categories, particularly since the implementation of the Medicaid Early Intervention Program, has also been affected.

Another recent positive development for the Part C system has been revision of **family cost participation practices** that help ensure statewide consistency and prevent denial of service due to inability to pay. Despite these changes, approximately 11 percent of children who are found to eligible do not access Part C services. Definitive reasons for this are not known but should be determined to ensure that children needing early interventions services receive them.

One recognized barrier to access of early intervention services appears to be persistent **lack of awareness regarding service availability**, particularly for underserved populations. An outreach campaign, “**The Earlier, the Better,**” was implemented by the Commonwealth a number of years ago, but out of necessity, funds for Child Find activities were diverted to direct services for children, and the lack of consistent outreach and public information efforts continues to deter early identification and front-loading of services.

In the early stages of life, hospital pediatricians, nurses, and discharge planners are critical sources of meaningful information for parents on available early intervention services, especially parents of infants receiving services in neonatal intensive care units (NICUs). Understandably, parents may not be able to receive or absorb much information while their child is in a NICU, and outreach efforts to them after the child been discharged can be invaluable in linking the child to early intervention services.

The Board recommends development and implementation of a formal follow-up program for families of children who have been in neonatal intensive care units, similar to the follow-up provided through the brain and spinal cord injury registry programs administered by the Virginia Department of Health.

In communicating with families, health providers must also be sensitive to cultural diversity and the ways in which culture affects delivery and access to services. As the Commonwealth’s population becomes ever more diverse, reaching families and children in meaningful ways becomes even more important in providing effective services. Information must be available in a timely manner and in understandable, accessible language and format. Health providers, as well as state agencies, must also plan communication with consideration for those who do not have access to a computer, which includes many of the elderly and the poor.

The 2010 *Report of the Virginia Health Reform Initiative Advisory Council*, produced at the direction of Governor Bob McDonnell, details the Commonwealth’s **continuing challenges in health care**. While not specific to individuals with disabilities, its key findings demonstrate how far Virginia has to go to develop a health care system that effectively serves all of its citizens. The report found that:

- “Nearly one million Virginians—and 150,000 children—lack health insurance and timely access to quality care that only it can ensure. Only 37 percent of small employers offer health insurance to their workers, a drop from 48 percent just ten years ago.

- “Virginia’s overall quality of care is average, with strengths in cardiac care, hospital care generally, and home health.
- “Health care spending is on an unsustainable path. Health care access, quality, and health status are inadequate for large numbers of Virginians.
- “By conventional measures of current workforce needs, demographic trends, retirement patterns and predicted replacement rates, Virginia is projected to soon have shortages of many health professionals on average, even without the impending coverage expansions expected from federal health reform. The scale of the projected coverage expansions will render all projected health professional supplies inadequate. We are therefore not likely to be able to provide care in the exact same ways we do now, for much longer.”

The report further noted that, although Virginia’s median family income ranks sixth among the states, it ranks 41st in breast cancer death rates and 35th in infant mortality rates despite improvements to newborn screening.

The 2006 and 2008 editions of the Board’s assessment addressed health care system issues as well. Most have not been mitigated and continue to be of concern, including:

- The lack of health insurance of over 1 million Virginians that limits access to health care for working citizens,
- The lack of dental care coverage under Medicaid for adults with disabilities,
- A shortage of health care providers willing and able to serve individuals with developmental and other disabilities,
- A lack of physical and operational accessibility and of reasonable accommodations in health care settings,
- Attitudinal and cultural barriers to health care access affecting both providers and individuals, and
- The need to improve coordination and continuity of care.

The health care system also remains fragmented and complex. Low provider reimbursement rates under Medicaid, as well as actual or threatened rate cuts due to the lingering effects of the recession on public revenues, pose challenges to the availability of affordable quality health care. Public comments to the Board indicate that access to health care providers who accept Medicaid (or Medicare) reimbursement is growing more difficult. Individuals who earn too much to afford private health insurance continue to fall through the cracks, and they are more likely to defer treatment until a health problem becomes severe, leading to more expensive interventions, including emergency room use.

The most significant recent development in national health care policy was the U.S. Congress’ passage of the *Patient Protection and Affordable Care Act* in 2010. Its long-term impact at the state level is uncertain at this time, since Virginia and many other states have filed

legal challenges to its implementation. Regardless of the outcomes of these challenges, it is clear that there must be significant changes with respect to access to, delivery of, and payment for health care, especially long-term care services for individuals with disabilities. The Commonwealth wisely made the decision to begin the implementation process and plan for key changes, such as electronic health records and health care exchanges, to improve the sustainability and effectiveness of the health care system.

As Virginia moves forward to improve its health care delivery system, keeping the needs of individuals with disabilities at the forefront of all discussions is paramount. Since service needs vary in scope and type by individual, a one-size-fits-all model will not be effective in achieving either desired health outcomes or cost control. Appropriate services and supports, including wellness care, delivered at the time and level needed, especially for infants and youth, will keep people healthier and more functional, avoiding more costly care.

As expenditures for public insurance programs such as Medicaid show, Virginians with disabilities, from infants and toddlers to the ever-growing elderly population, rely disproportionately on public services. The Virginia Department of Health (VDH) and its network of local health departments play a key role in providing access to these services. Local health department clinics are often the primary—or only—point of contact for access to services by low-income individuals and families. The regional Child Development Clinics provide comprehensive assessments that otherwise might not be available to youth. At this time, however, too little data is collected on utilization of public health clinics and related publicly funded programs by individuals with disabilities. For example, it is unknown how many individuals with disabilities receive dental care through medical school or health clinic programs.

To support planning by the Virginia Health Reform Initiative, **the Board recommends** that the state's Department of Health develop and implement a data collection system that will, where feasible, monitor the services provided to individuals with disabilities.

To ensure accessibility to health care for people with disabilities, increased outreach to the general medical community will also be required. The Commonwealth must improve expectations for training of all health professionals, beginning with the curricula at graduate and medical schools. Their students must be trained in person-centered practices, self-determination, and accessibility. Continuing education for current practitioners needs to be expanded to include these topics as well. To encourage more providers to serve individuals with disabilities, reimbursement rates for Medicaid must be restructured to establish parity with payments by private insurance plans. Additionally, those rates should be adequate to cover accessible equipment and other operational costs incurred in providing services for individuals with disabilities.

As in 2008, **the Board recommends** that incentives should be created or expanded to ensure that health professionals across the state establish and maintain inclusive and accessible practices.

Dental hygiene and preventative dental care have long been recognized as important to overall health and well-being for everyone. Regular dental care prevents plaque build-up and tooth decay that, if untreated, can develop over time into more serious, systemic infections or necessitate more expensive tooth extraction. Despite this, the state Medicaid program still does not cover routine dental services for adults, even though it does cover more expensive dental surgery and related procedures that might have been avoided through routine dental care. Moreover, Medicaid reimbursement rates for dental care remain below the costs for services, especially when specialized equipment, instruments, or staff with additional training may be needed and dental practices may experience higher liability insurance rates for employing them.

The Board recommends that:

- Dental coverage be added as a Medicaid State Plan service for adults,
- Medicaid reimbursement rates be increased to cover the true costs of dental services for all individuals, and
- The Department of Medical Assistance Services analyses of costs and benefits include examination and identification of the long-term cost avoidance that could be gained by providing preventive dental care for adults.

As indicated above, Medicaid is essential to receiving services and supports for many individuals with disabilities. In administering and ensuring fiscal accountability for this public insurance program, the Virginia Department of Medical Assistance Services (DMAS) has kept administrative overhead lean and implemented a number of best practices for quality assurance and cost effectiveness. For several years, DMAS has also conducted extensive outreach to families to expand Medicaid enrollment of children and youth. These outreach efforts, increased enrollment of individuals due to the economic downturn, and rising health care costs have made Medicaid the second largest expenditure in Virginia, and its expected continued growth is of concern to the state legislature. Nevertheless, as recognized by JLARC and legislative studies, Virginia's Medicaid reimbursement rates for Medicaid Home and Community Based Services (HCBS) Waivers are lower than those of other states and have not been adjusted for inflation.

The Board recommends that the Virginia Health Reform Initiative examine reimbursement rates for services under the Medicaid State Plan and for Medicaid Home and Community Based Services Waivers in comparison to private insurance rates and identify options to maintain or expand the pool of health care and related providers who serve individuals with disabilities.

During the past two sessions, the Virginia General Assembly has taken a number of **legislative actions addressing Medicaid HCBS Waivers and services** available through them. In the three years prior to the 2010 session, Medicaid data had shown a dramatic increase in the number of individuals enrolled in the Elderly or Disabled with Consumer Direction (EDCD) Waiver. The number of persons on waiting lists for the Intellectual Disability (ID) Waiver and Individual and Family Developmental Disability (DD) Waiver had grown significantly as well, and capacity was nearly reached for Day Support Waivers in state fiscal year (SFY) 2010. In response, the 2010 legislature directed DMAS and the Virginia Department of Behavioral Health and Developmental Services (DBHDS) to produce a plan with cost estimates for eliminating the ID and DD waiting lists by SFY 2020. Their analysis indicated that it would require funding of 1,100 new ID Waiver and 220 new DD Waiver slots per year for SFYs 2011 through 2020. Their study, however, did not examine the potential long-term savings that could be obtained through avoidance of expenditures for emergency care and institutional services.

Senate Bill 194, passed by the 2010 General Assembly and signed by the Governor, addressed an important Medicaid HCBS Waiver issue covered by a recommendation in the Board's 2008 assessment. As a result of this bill, individuals with disabilities receiving consumer-directed services under a Medicaid HCBS Waiver can obtain certain skilled services, such as insulin injections, without needing to have a nurse provider. Individuals with disabilities and their advocates fought hard for this change, an important reform with significant impact that will enable greater personal control over services that an individual would normally be able to self-administer if not for his or her disability.

The worsening effects of the recession on state revenues, however, also resulted in budget proposals during 2010 to reduce critical supports that would threaten the ability of individuals with significant physical or medical disabilities to remain at home. These included limitations on assistive technology and environmental modifications, reductions in respite care from 720 to 240 hours per year, and a cap of 40 hours per week on personal care services under the Medicaid HCBS Waivers.

Fortunately, the 2011 General Assembly passed several budget amendments that restored or lessened these cuts. Annual allowances for environmental modifications and assistive technology were maintained at \$5,000, rather than being reduced to \$3,000. Respite hours were partially restored to a maximum of 480 hours per year. Agency- and consumer-directed personal care hours under the Alzheimer's, EDCD, and HIV/AIDS Waivers were capped at 56 hours per week, for a total of 2,920 hours annually, but DMAS was directed to develop provisions for individual exceptions based on an individual's dependency in activities for daily living (ADLs), level of care, and risk of institutionalization. The cap does not affect services under the ID, DD, and Technology Assisted Waivers.

The 2011 legislature also approved funds for 275 new ID Waiver and 150 new DD Waiver slots. It further tasked DMAS and DBHDS with examining ways in which Medicaid HCBS Waivers could be improved or developed for individuals with intellectual or other developmental disabilities that would enable more people to be served in the community,

including those with high medical or behavioral needs, and would increase both efficiency and cost effectiveness (2011 Budget Item 295.1). Their report to the legislature is expected by October 1, 2011.

The Board applauds and supports this new Medicaid Home and Community Based Services Waiver initiative (2011 Budget Item 295.1) by the Virginia General Assembly to promote efficiency and effectiveness, and as in 2008, **the Board recommends:**

- Development of a “universal,” non-disability-specific waiver that offers a full menu of supports based on individual need;
- Analysis by the Department of Medical Assistance Services (DMAS) of future Medicaid costs and savings, including costs avoided for maintenance and upkeep of facilities by serving individuals in the community rather than in institutions;
- Collaboration by the Department of Behavioral Health and Developmental Services and DMAS to develop a waiver waiting list database that would include sufficient information on services actually needed to improve services planning and redesign; and
- Regular analyses of actual service utilization by DMAS that can be used to project needed capacity for various Medicaid services.

Many children, youth, and adults with disabilities require specialized services and supports in order to achieve independence and succeed in **education and employment**. As in many other areas of its assessment, the Board finds that most of the education and employment challenges cited in its 2006 and 2008 assessments remain.

A repeated key finding is that local control of Virginia’s public education system results in significant variability in the adequacy, level, and effectiveness of **educational services for children in grades kindergarten through 12**. While recognizing that local control is a core feature of the Commonwealth’s public education system, the Virginia Department of Education (VDOE) needs to continue efforts to improve accountability and achievement among localities. Disproportionate representation of minority students in special education is one concern, identified by both federal and state officials since 2005, that has been successfully addressed in recent years. Corrective action plans were developed and enforced, and this is no longer cited as an issue of noncompliance. Monitoring by VDOE, however, should be ongoing, even if it is not required by the federal government, to ensure that the Commonwealth serves its minority students with disabilities in an effective manner. Other areas of improvement since the Board’s 2008 assessment include:

- Closure of the underutilized and frequently criticized Virginia School for the Deaf, Blind, and Multi-Disabled in Hampton, allowing students to either be integrated into their local schools or to receive specialized services at the Virginia School for the Deaf and the Blind in Staunton;

- Fewer referrals to special education as a result of implementing a Response to Intervention (RTI) program at 15 pilot schools;
- Re-establishment of teacher preparation programs for teachers of individuals who are vision impaired at several universities; and
- A notable increase among students with disabilities in performance on standardized tests.

The good news noted in the last bulleted item above is tempered by the fact that standardized tests indicate a continuing disparity in achievement and graduation rates for students with disabilities, who have the lowest rate of obtaining a diploma within four years. Students with disabilities also score the lowest among all student subgroups, including students with limited English proficiency and those classified as economically disadvantaged. As a group, students with disabilities achieve a proficiency in mathematics and English that is eight to ten percentage points below established targets. A recent improvement has been participation by students with autism in VDOE's National Professional Development initiative, and results to-date, albeit limited, are positive.

The Board recommends that the Virginia Department of Education identify and continue to promote proven, evidence-based academic strategies that improve performance by and graduation rates for students with disabilities.

Federal special education laws mandate that students with disabilities be served in the "least restrictive environment." Despite this, with the notable exception of Montgomery County Public Schools, most school divisions across the state still have segregated self-contained classrooms, playgrounds or recreational activities, and even entire schools as a mainstay of their special education systems. Data shows that Virginia's targets for serving students in the least restrictive environment have not been met. Through due process and complaint filings, as well as public comment, parents continue to report a lack of qualified teaching staff, inaccessible schools and transportation, and a lack of support for inclusive educational practices. Increased and improved training for regular education and special education teachers is paramount.

The Board recommends that:

- The Virginia Department of Education provide increased technical assistance to school divisions to achieve least restrictive environment targets and implement enforcement actions when school divisions remain noncompliant over time, and
- College teacher education programs as well as continuing education for general education teachers include mandated components on collaborative learning, inclusive classrooms, diverse learning and instructional strategies, and behavioral supports.

Parents continue to comment on low expectations for their children by teaching staff, and of major long-term significance to their future, students with disabilities are too often directed

away from participation in the general Standards of Learning (SOL) curriculum and the standard or advanced diploma tracks. Families additionally voice confusion regarding the state's accountability process and that there are four different assessment tests from which to choose. Schools must ensure that students and their families understand the implications of curriculum and diploma choices on children's futures. Legislation passed in 2010 that requires documented justification when students are diverted away from the SOL assessment tests is a hopeful improvement.

The Board recommends that the Virginia Department of Education implement a monitoring process for local school system Standards of Learning diversion justifications in order to identify problem areas, provide technical assistance to localities, promote best practices, and enforce compliance.

Services for students with autism spectrum disorders (ASDs) continue to be a priority at the state and local levels as their numbers increase. The number of children identified as having an autism educational classification grew from 3,954 in 2003 to 10,092 in 2009, and when the 2010 Child Count is available in the spring of 2011, it is anticipated to be even higher. To better effect educational improvements, VDOE created an Office of Instructional Supports and Related Services in its Special Education Division. That office worked with JLARC on its 2009 *Assessment of Services for Virginians with Autism Spectrum Disorders*, which provides a blueprint for improving services for individuals with autism during all stages of life. Then, in 2010, VDOE established the Autism Center for Excellence in collaboration with Virginia Commonwealth University's School of Education and Rehabilitation Research and Training Center.

The Board supports the Joint Legislative Audit and Review Commission's 2009 recommendations for actions to improve autism services **and further recommends** that the Virginia Department of Education evaluate initiatives to improve educational services for youth with autism spectrum disorders to determine their impact on actual local practices and their effect on systemic change. This evaluation should be ongoing, and its findings should be published regularly.

Ongoing reductions in both state appropriations for local education agencies and local government funding are resulting in larger class sizes, reduced curriculum offerings, and less support for paraprofessionals in classrooms, all of which potentially contribute to widening of achievement gaps between students with and without disabilities. These budget cuts pose a major threat to meeting students' needs and further hamper inclusive school practices by depriving teachers of needed support.

The lack of **transition services** to life after high school is another ongoing concern for students with disabilities and their parents, whether those students will be graduating with their class or receiving education services through age 21. Although federal law assigns the primary

responsibility to provide transition services for students with disabilities to local school divisions, the participation of vocational rehabilitation agencies, Community Services Boards, and other state and local agencies is critical to successful transition to post-secondary options. Early in the transition process, which should begin no later than age 14 in Virginia, schools need to better coordinate with public and private agencies that are already working with a student or that can play a major role in preparing him or her for post-secondary education or employment.

Public comments to the Board continue to express dissatisfaction with the time at which the Department of Rehabilitative Services (DRS) becomes involved in the transition process for students as well as with the frequency and scope of the services that DRS provides for transition. This same concern has not been cited with respect to individuals accessing services from the Department for the Blind and Vision Impaired (DBVI), perhaps because DBVI provides “cradle to grave” services and these students and their families may already have connections with DBVI. The Board recognizes that DRS involvement may be hampered by a lack of timely referrals by schools; however, a new and very significant barrier is the recently announced “Order of Selection” limiting access to vocational rehabilitation services that DRS implemented effective March 1, 2011, which is discussed in more detail below. Whatever the difficulty, the Board believes that ensuring the best possible preparation for a child’s future should be a public priority.

The Board recommends that the Governor, through the respective Secretariats, charge the directors of the Department of Education, Department of Rehabilitative Services, Department for the Blind and Vision Impaired, and Department of Behavioral Health and Developmental Services to:

- Conduct a formal study of current processes and practices in transition services that will identify root causes of barriers to timely initiation of transition services and involvement of agencies in their planning and delivery, solutions to overcome those barriers and inefficiencies in the current system, and model transition processes and practices of other localities;
- Develop best practice guidelines for early interagency involvement in the transition process;
- Direct agency resources to ensure that coordinated transition planning and services occur at the local level; and
- Through improved data collection and analysis, monitor outcomes for students with disabilities over time.

Finding and maintaining employment for both students and adults with disabilities is a challenge complicated by a current employment services system that is fragmented and complex, with the Department of Rehabilitative Services (DRS), the Department for the Blind and Vision Impaired (DBVI), the schools, Workforce Centers, and various other agencies providing different employment-related services. The Board’s 2006 and 2008 assessments identified their

differing points of entry, application processes, and eligibility requirements as a considerable barrier to employment. Services currently available for individuals with disabilities, especially those with significant disabilities, are often inadequate, and expansion of vocational service capacity—a major overarching issue—requires development of not only job sites, but also individual training, placement, job coaching, and worksite accommodations such as assistive technology, workplace accessibility, and personal assistance services.

At the time of the Board’s assessment, budgetary issues further complicate access to employment and vocational services and supports for individuals with disabilities. Both DRS and DBVI were able to close previous Orders of Selection and serve more clients due to the infusion of federal “stimulus” funds provided through the *American Recovery and Reinvestment Act* (ARRA); however, those funds end in September 2011, and both agencies face fiscal challenges meeting the state match requirements for drawing down federal funds in the future. As a result, DRS reinstated its Order of Selection in March 2011, closing access to its vocational rehabilitation services for all categories of new applicants. Individuals may still apply for services, but those found to be eligible will be placed on a waiting list. DBVI is expected to reinstate its Order of Selection later in 2011. As noted above, students with disabilities are disproportionately affected by these Orders of Selection as new applicants seeking services to transition into advanced training, post-secondary education, or employment.

The Board recommends that:

- The Commonwealth provide sufficient state funding to eliminate vocational rehabilitation waiting lists for students ages 14 through 22, thereby drawing down additional federal funds; and
- The Joint Legislative Audit and Review Commission conduct a study of the effectiveness of current employment services for individuals with disabilities that will provide recommendations for system restructuring, as necessary, to improve individual employment outcomes.

Loss of benefits, especially eligibility for Medicaid, if their earnings are too high is a concern for many Virginians with disabilities seeking employment. The Virginia Health Reform Initiative report referenced earlier found that only 37 percent of all private employers in the state now offer health insurance. It also found that the cost of insurance premiums grows two to three percent faster per year than personal income and that some working Virginians need subsidies to afford the insurance needed to access appropriate care. As a result, many with a chronic health condition either do not seek employment or limit their hours of employment or wage levels.

MEDICAID WORKS, which addresses this issue, and other work incentives such as the Plan for Achieving Self-Support (PASS) and the Impairment-Related Work Expenses program exist, but many individuals with disabilities, their families, employment services professionals, and employers are not fully informed about them. Because eligibilities differ and regulations change periodically, ongoing outreach that brings up-to-date information to their target audiences

is essential to improve the utilization of these work incentives. An intensive training program sponsored by the Board, DRS, and the Department of Medical Assistance Services (DMAS) for state agencies, disability professionals, people with disabilities, and their families demonstrated this. Following the training, use of the 1619(b) work incentive allowing individuals to work while retaining Medicaid grew from 1,441 individuals in 2003 to 2,018 in 2007, a 40 percent increase. Based on this and other evidence, the Board believes that increased coordination among state agencies and federal Work Incentive Projects is indicated to better inform individuals about work incentives and encourage enrollment.

The Board recommends ongoing training and technical assistance about employment services and work incentives for staff members in state and local agencies serving people with disabilities, particularly local social services agencies and public school transition personnel, who may be the first point of contact for many individuals with disabilities.

Resources allocated for employment preparation are a valuable investment for the Commonwealth over the long-term. Employment services for individuals with disabilities can enable them to become more independent, productive employees and taxpayers that are less dependent on government services.

Virginia continues to operate many facility-based (sheltered workshop) employment programs that neither provide a competitive wage for individuals with disabilities nor help develop skills valuable to employers and constitute a form of segregation. This over-reliance on facility-based employment was noted in the Board's 2006 and 2008 assessments and was recently identified as an issue by the U.S. Department of Justice (DOJ) in its investigation finding that Virginia is in violation of the integration mandate of the *Americans with Disabilities Act* (ADA).

Other states have adopted an “**Employment First**” approach, in which training and education are provided to individuals with disabilities and their families, educators at all levels, state agencies, service providers, and employers not only to change expectations about the capabilities of individuals with disabilities, but also to promote regular employment versus day support or sheltered workshops as the first option for adult life. The State Employment Leadership Network (SELN), a statewide group of employment stakeholders that includes individuals with disabilities and is spearheaded DRS, is promoting an Employment First policy for Virginia, but a resolution calling for such a policy was defeated in the 2011 General Assembly. The SELN has also determined, and the Board concurs, that current Medicaid Home and Community Based Services (HCBS) Waiver reimbursement rules discourage individual, competitive employment placements.

The Board recommends that Virginia adopt an “Employment First” policy in which competitive, integrated employment is promoted as the first expectation for individuals with disabilities, and as a part of implementing this policy, **the Board further recommends:**

- Removal of the reimbursement rate differential that acts as a disincentive to competitive employment by increasing the individual supported employment rate so that it is greater than the facility-based employment rate and day support rate;
- Amending Medicaid Home and Community Based Services Waiver regulations, as recommended by the State Employment Leadership Network, so that individuals can access transportation via the Waiver for work purposes rather than have to be picked up at a waiver provider and dropped off at a waiver site; and
- Monitoring and data collection and analysis of outcomes for individuals with disabilities engaged in integrated, competitive employment to demonstrate the economic and social benefits over facility-based or day support programs.

As with employment services, the Board’s previous and current assessments have found the system of **community supports** to be fragmented and complex, requiring individuals with disabilities and their families to seek services from multiple state agencies and private nonprofit or for-profit entities. For the average citizen, just finding information on available state-funded or operated services can be challenging. Recent efforts to address this challenge, through the state’s “No Wrong Door” initiative, created the Virginia Easy Access online information resource. Although it was conceived as a one-stop source of information and referral for long-term care services, public comments and proposed 2011 legislative action indicate that it has not proved as user-friendly as anticipated and that it is underutilized. It is also limited to information on adult services and resources. To address some of these concerns, the Virginia Department for the Aging (VDA), which leads the No Wrong Door initiative, has been establishing local VirginiaNavigator Centers across the state as a walk-in resource for locating and completing applications for services. None of these initiatives, however, have had meaningful funding and a systemic plan by which to raise public awareness about their availability and promote their use statewide.

While it applauds state efforts to create and maintain a single source with which citizens can locate needed services, **the Board recommends** that:

- Current efforts towards that end across agencies be consolidated to prevent redundant efforts and create a true one-stop for information that includes resources relating to children with disabilities, and
- An outreach and marketing plan be developed and implemented through the Health and Human Resources Secretariat to inform citizens of the availability of these resources.

Assistive technology (AT) is an important tool that enables many individuals with disabilities to maintain independence, communications, or mobility. In recent years, with support from multiple grants, the Department of Rehabilitative Services (DRS) has worked to make AT more affordable and available through expansion of regional recycling centers that refurbish and adapt AT, as indicated, for reuse. In a related AT effort, the Woodrow Wilson Rehabilitation Center, operated by DRS, has actively promoted use of affordable electronic devices and other home technologies that assist individuals with disabilities in maintaining their independence.

In contrast with the recent expansion of regional AT recycling projects by DRS, financial pressures from the recession and slow economic recovery following it have severely constrained activities by other local elements of the service system as funding for key providers has been reduced. Lack of state funding has most severely impacted access to services by individuals with intellectual, developmental, and other disabilities who are uninsured or underinsured and do not qualify for Medicaid public insurance. These individuals often have no other option for services. For example, increased federal funding has expanded some services for former and current military personnel who have traumatic brain injuries, but state funds have not been allocated to expand services for other individuals with traumatic brain and spinal cord injuries.

Centers for Independent Living (CILs) are invaluable community resources for information and referral, peer counseling, training, and advocacy for individuals of all ages and with all types of disabilities. They support self-determination, independent living, and community integration by linking these individuals and their families to the services that enable persons with disabilities to remain in their homes and communities. They have also played a significant role in facilitating transition of individuals from institutional placements to community settings, first through the Board's nursing home outreach grant programs and then under the federal **Money Follows the Person** initiative. CILS still do not cover all localities across the state, and although some funding cuts were restored in Virginia's 2010 budget, additional funds are needed to establish CILS and provide their important services in unserved communities.

Local **Community Services Boards (CSBs)** administer a wide range of services for individuals with intellectual disabilities, both directly and through a network of private sources. CSBs, which receive state general funds, have historically been underfunded and experienced additional budget cuts in the three years prior to the Board's assessment. In 2009, Virginia finally created a state agency responsible for planning and coordination of developmental disability services, giving this responsibility to the Department of Behavioral Health and Developmental Services (DBHDS). The General Assembly did not allocate any funds, however, to expand developmental disability services at either the state or local level, and at present, most CSBs serve individuals with developmental disabilities only if they have a concurrent diagnosis of intellectual disability.

The Board recommends that the General Assembly prioritize expanded funding for disability services provided by public and private entities charged with service delivery to improve community capacity and to prevent institutionalization or re-institutionalization of individuals with disabilities, especially those who are uninsured or underinsured.

Adequate **system oversight** is essential to ensuring safety and quality of care for individuals with disabilities. For many years, staffing of licensure and related oversight functions at various disability agencies remained static despite dramatic increases in the number of community providers, programs, and service locations, then in state fiscal year (SFY) 2008, staffing was cut. This compromised the state's capacity to provide meaningful oversight over community- and facility-based programs. Legislative funding of additional licensure positions at DBHDS in 2011 was a promising sign; however, more positions are needed there and at other state oversight agencies. Better planning and implementation of oversight functions will be critically important as Virginia seeks to address the recent U.S. Department of Justice findings mentioned above and to transition individuals from institutional services to community supports.

In response to expanding community services for individuals with disabilities, **the Board recommends** that the Secretary of Health and Human Resources initiate a study of state agency oversight and quality assurance functions for community services that includes projections of staffing needs for the next six years.

When given the option, individuals with disabilities are no longer choosing to live in institutions, and as evidenced by the Money Follows the Person initiative, even individuals who were placed in institutions such as nursing homes many years ago want to have a home in their communities. The expectations of individuals with disabilities and their families have also evolved beyond artificial housing models, misnamed as "community integration," that feature large congregate group settings with little personal choice or control. They expect to have the same choices available to individuals without disabilities, such as apartment living with or without a roommate, home ownership, house sharing with friends or housemates of their own choosing, and living with family. These new expectations impact not only **community housing**, but the service system as a whole, reflecting an *à la carte* approach in which a "service package" based on a person's unique circumstances and choices can be individually designed. This growing emphasis on a community-based system of long-term care services is a national movement firmly grounded in law, public policy, and public opinion.

Although some changes are ahead, Virginia continues to have a public service system with an institutional bias. The Commonwealth funds and operates five **state training centers**, licensed as **intermediate care facilities for persons with mental retardation (ICFs-MR)**, for individuals with intellectual and related developmental disabilities (ID/DD). The state also has the tenth largest population among the states of individuals served in state institutions (approximately 1,100), and is one of ten states that have not closed any of their large state-operated ID/DD institutions. Nevertheless, as in other states, the training center census has been

declining and will continue to do so because of decreases in admission requests and increased demand for community options. Buildings at Virginia's training centers are at least 35 years old, with some being much older, and operational and maintenance costs for these structures and equipment have increased dramatically over time. Despite their on-going downsizing, these training centers will receive \$7.1 million in state fiscal year (SFY) 2012, an amount that will restore previous budget cuts and improve staffing ratios.

Moreover, between SFYs 2005 and 2010, the number of **community ICFs-MR** increased from 15 to 36 statewide, with a total capacity of 391 beds at the end of SFY 2010. Capacities ranged from four beds to 88 beds at the state's largest community ICF-MR, St. Mary's Home for Disabled Children, a specialized ICF-MR for children and adolescents in Norfolk, with most having eight or more beds. Youth ages one to 20 comprised 26.9 percent of community ICF-MR residents in SFY 2010, adults ages 21 to 64 comprised 68.8 percent, and 4.3 percent were ages 65 or older.

Far surpassing training centers and community ICFs-MR in number and capacity, 279 **nursing facilities (nursing homes)** operated in Virginia during SFY 2010. These facilities serve, and have served, individuals with developmental and other disabilities of all ages. Using the federal category of "blind and disabled" that includes those with ID/DD or acquired disabilities, the Department of Medical Assistance Services (DMAS) reports that 5,759 individuals were served in these facilities in SFY 2010, an increase of 14.1 percent over the 5,048 served in SFY 2007. While the state's training centers served only seven youth ages 21 or younger, community ICFs-MR served 105 youth, and nursing facilities served 89.

Resident counts specific to individuals with ID/DD served by nursing facilities in Virginia varies by source due to differing definitions of that population and differing data collection systems. Data from DMAS, based on information from the Uniform Assessment Instruments (UAI) that it receives, show that 906 individuals with ID/DD were served in nursing facilities in SFY 2010. That is an undercount, since DMAS has received UAIs on only 64.4 percent of all those served under Medicaid. In contrast, the Coleman Institute at the University of Colorado reports data collected from both state ID/DD agencies and from the federal Centers for Medicare and Medicaid (CMS) Online Survey, Certification, and Reporting (OSCAR) system. Its most recent national report indicated the count as being 1,184 in SFY 2009. The University of Minnesota reports an even higher count of 2,877 in SFY 2009.

Both ICFs-MR and nursing facilities rely on public insurance for funding, primarily Medicaid and to a lesser extent Medicare, and concerns about the sustainability of Medicaid must take into account the role and costs of serving individuals with ID/DD in institutions. In SFY 2010, the annual per capita cost of providing services in a training center was \$195,574, compared to \$137,552 in a community ICF-MR. The *Genworth 2010 Cost of Care Survey* indicated that the 2010 median per capita cost for services in a Virginia nursing facility ranged from \$65,700 to \$73,000.

The state's institutional bias is contrary to the clear choices made by individuals with ID/DD and their families to live in and be part of their communities. The U.S. Department of Justice's February 2011 notice of findings points out that segregation in institutions both harms individuals, through such effects as learned helplessness and a lack of or loss of skill development, and is contrary to the *Americans with Disabilities Act* (ADA). The state Inspector General for Behavioral Health and Developmental Services also determined that those in Virginia's training centers could be served in the community.

Steps taken in other states show that planning for downsizing or potential closure of the state's training centers must be concurrent with planning for development of appropriate community infrastructure and oversight systems. Research also indicates that, while they initially rise during this process, total Medicaid costs decline after several years. Virginia stands to benefit fiscally in other ways as well. When an institution closes, substantial costs for building maintenance will be avoided. Surplus land can be sold and revenues from those sales applied to support community services, expanding jobs related to disability services beyond just those localities where institutions are currently situated to all communities. The 2011 General Assembly took a meaningful step in this direction by supporting the Governor's proposed \$30 million "down-payment" to build community service capacity for persons with ID/DD with the appropriation of that amount to create a **Trust Fund for Behavioral Health and Developmental Services**.

The Board recommends that state and local policymakers, in coordination with individuals with disabilities, advocates, service providers, and other stakeholders, fully analyze the design and operation of the state and local services system for individuals with intellectual and developmental disabilities. This analysis should then be used to develop workable, sustainable changes, with specific implementation timelines and resource requirements, that will expand disability services at all levels consistent with the tenets of community inclusion and integration as well as individualized supports based on need, not diagnosis or program availability. While some efforts in this direction are already underway, greater attention is needed to system elements that support institutional services over community supports.

The Department of Behavioral Health and Developmental Services' (DBHDS) development of and continued efforts on its *Creating Opportunities* plan are a good start, and the agency is commended for its inclusion of diverse stakeholders. As these efforts continue and expand, however, the Board cautions that planning must be careful to prevent "trans-institutionalization," the movement of individuals with ID/DD from one type of institution, such as the training centers, to another type of institution, such as community ICFs-MR or nursing facilities. Census trends at institutions for all populations, but especially for youth and young adults, also merit ongoing scrutiny. Factors leading to institutional placements should be

identified and addressed. The need to do so will become increasingly more important because of federal requirements that nursing facilities determine whether individuals are interested in and prefer community supports as a part of their annual service planning process.

Tracking these activities are complicated by the **lack of reliable, valid data** on the number and characteristics of individuals with ID/DD served in community ICFs-MR and especially in nursing facilities. As referenced above, in preparing its assessment, the Board found that nursing facility residency counts varied dramatically depending on which agency database and methodology was used. This problem has been substantiated by researchers at the University of Minnesota and University of Colorado, which each produce annual national reports on residential services for individuals with ID/DD. For Virginia's Health Reform Initiative to develop effective long-range plans, it is vital that it have access to accurate and consistently determined information addressing these and other issues affecting services for individuals with disabilities.

The Board recommends that the Secretary of Health and Human Resources:

- Task the Department of Health, Department of Medical Assistance Services, and Department of Behavioral Health and Developmental Services with developing a common methodology, including diagnostic categories, for identifying and tracking individuals who are served in non-state-operated institutions by age and by whether they have an intellectual or other developmental disability;
- Establish a lead agency for monitoring and reporting annual data trends; and
- Incorporate this data into planning as a part of the Virginia Health Reform Initiative.

Affordable, accessible housing is critical to successful community integration, and the U.S. Department of Justice's (DOJ) Office of Civil Rights is increasingly holding states more accountable for enforcement of the community integration mandate under the *Americans with Disabilities Act* (ADA) and the U.S. Supreme Court's *Olmstead v. L.C.* decision. In support of greater community integration, recent federal initiatives have been and are providing incentives for states committed to related changes in policy, systems design and funding models. These include the Money Follows the Person demonstration project funded by the Centers for Medicare and Medicaid Services (CMS), passage of the *Frank Melvin Supportive Housing Act* by the 111th U.S. Congress, and the U.S. Department of Housing and Urban Development's (HUD) *Notice of Funding Availability for Housing Choice Vouchers* targeting nonelderly people with disabilities. There will be additional opportunities for states to obtain federal funding and technical assistance through similar grants and demonstration projects promoting systems change, and Virginia needs to proactively position itself to capitalize on these opportunities.

At the time of the Board's assessment, the Commonwealth still lacks a **comprehensive housing policy**; however, the *Governor's Executive Order No. 10*, issued in April 2010, calls for establishment of a *Housing Policy Framework* that will align priorities, goals, and resources strategically in a coordinated manner. On November 18, 2010, the workgroup fulfilling this executive order submitted an interim report to the Governor that stressed the importance of addressing the lack of community housing options for people with disabilities. Noting the *Olmstead* mandate for state community integration strategies, the report concluded that Virginia has a "...growing need to reduce institutionalization and provide more integrated community housing alternatives for special need populations." It also highlighted the common barriers to community housing for individuals with disabilities: affordability, accessibility, and coordination of services.

With respect to affordability, people with disabilities who rely on Supplemental Security Income (SSI) benefits as their only income continue to be some of the poorest Virginians, able to afford a monthly rent of no more than \$191 per month (30 percent of the \$674 monthly SSI benefit at the time of the Board's assessment). In the 2009 *Appropriation Act* (Budget Item 315 Z), the General Assembly called for a study that would "...report on investment models and best-practices for the development of affordable and accessible community-based housing for persons with intellectual and related developmental disabilities." The Department of Behavioral Health and Developmental Services (DBHDS) was given responsibility for leading this study in collaboration with the Virginia Housing Development Authority, the Department of Housing and Community Development, the Virginia Association of Community Services Boards, The Arc of Virginia, and the Virginia Network of Private Providers. Although the Board was not a mandated participant, it was a key contributor to the study's comprehensive overview of affordable housing barriers, current resources, and opportunities and to its specific recommendations for implementing expanded housing options.

To-date, attempts to establish a Housing Trust Fund for Virginia have also been unsuccessful, and as the state explores resource reallocations and other changes needed to rebalance its long-term care system, increased efforts are needed to obtain a commitment of resources for integrated housing options and choices. The *National Affordable Housing Trust Fund Act* of 2008 dedicates funding for the production, preservation, and rehabilitation of 1.5 million affordable homes over ten years. At least 67.5 percent of the funds it provides to states must be spent on rental housing for households with incomes at or below 30 percent of state median income. Virginia is expected to receive approximately \$19 million in federal funds through this legislation, but their release date has not been confirmed.

A significant contributing factor to the shortage of accessible housing is the lack of awareness of the *Fair Housing Act*, the *Americans with Disabilities Act (ADA)*, and the general principles of "universal design" and accessibility among builders, inspectors, landlords, and realtors. For the fourth consecutive year, HUD's 2009 *Annual Report on Fair Housing* identified

disability as the most common basis for housing discrimination complaints filed with fair housing and equal opportunity agencies. Resistance to the development of housing options for people with disabilities exists in some localities as well, largely due to misconceptions and inaccurate stereotypes. Available data further supports the need for increased outreach and education to raise awareness and understanding among key local stakeholders.

To expand the availability of affordable, accessible housing options, **the Board recommends** that:

- Cross-Secretariat collaboration be sustained to implement the housing policy recommendations and next steps identified in the *Report on Investment Models and Best Practices for the Development of Affordable and Accessible Community Housing for Persons with Intellectual and Related Developmental Disabilities* (2009 Budget Item 315 Z);
- The Commonwealth develop a mechanism to overcome critical funding gaps limiting development of affordable housing for people with disabilities through targeted application of state funds that make investments of private capital more feasible;
- Virginia make the housing needs of people with disabilities a priority and ensure that fair housing laws and policies are upheld and enforced in planning for and dispersal of its National Affordable Housing Trust Fund allocation; and
- Compliance with the *Fair Housing Act* be rigorously enforced and that statewide outreach and education strategies to inform builders, developers, realtors, housing counselors, elected officials, and community organizations about the law be developed and implemented.

Coordinated local planning for housing, transportation, employment, and other land uses is critical if tangible improvements in community living opportunities are to be realized, and of these, **transportation issues** continue to be one of the most frequently cited barriers to full community inclusion for people with disabilities. Reliable transportation is essential to maintain employment, receive medical other health care services, shop for groceries and other personal needs, and participate in recreational or civic activities. To address these issues, the Department of Rail and Public Transportation (DRPT) has worked closely with localities to develop Coordinated Human Services Public Transportation Planning Models. While significant gains have been achieved in these efforts, continued planning and implementation of coordination strategies are needed.

Many individuals with and without disabilities rely on dependable public transportation for their basic mobility, and the current strain on local fiscal resources is making it increasingly difficult for localities to provide stable, adequate annual appropriations for public transportation.

Localities also lack resources to make investments in sidewalks and curb cuts that create unobstructed pedestrian routes and ease travel through neighborhoods to public transportation and other destinations. Opportunities exist to access federal resources supporting local transportation coordination efforts, but many localities have been inconsistent in planning for the matching funds required to obtain those federal funds.

The true cost of transportation services by many human services is also difficult to determine because they are not tracked by trip and passenger, making it difficult for policymakers to compare costs per unit of service. Human services agencies also frequently do not account for all costs associated with providing transportation, such as vehicle maintenance and upkeep, related office space and equipment, and comprehensive accounting of staff costs. Because providers do not use uniform methods of data collection, a universal method of evaluating the success of a particular location's transportation coordination efforts is not available.

Virginians with disabilities continue to express complaints and concerns to the Board about the quality of both paratransit services and Medicaid-funded human services transportation, as well. An apparent lack of driver training and sensitivity to the diversity of disability populations and their needs and the lack of reliability are identified most often. While the full scope of the problem is not clear, individuals with disabilities report that, when drivers are late or just do not appear, they are often "penalized" for late arrivals or missed appointments by health care providers through additional charges or even discontinued services if it occurs repeatedly. Data maintained by the Department of Medical Assistance Services for human services transportation indicates that a sizeable proportion of complaints are for transport that is late or does not show, but it also indicates that fewer than one percent of all rides result in complaints.

To increase the availability and reliability of transportation for individuals with disabilities statewide, **the Board recommends** that the Commonwealth:

- Continue to emphasize development of coordinated planning models in local and regional planning and develop incentives that facilitate community development linking housing, transportation, and disability services;
- Encourage localities to include funding for public transportation as a line item in their budgets;
- Consider creating incentives for localities which designate matching funds for federal transportation dollars on a sustainable, long-term basis;
- Develop and implement a competency-based driver training curriculum for all human services transportation and public paratransit drivers that includes not only driver

safety, but also training on diverse disabilities, disability culture, and disability etiquette;

- Conduct regular monitoring of trends regarding complaints received by the Medicaid Transportation Advisory Council (MTAC) that transportation is late or does not show, which considers the impact of this problem on individuals with disabilities;
- Encourage local governments to include capital investments for accessibility enhancements and “universal design” features that remove travel barriers to individuals with disabilities in their annual budgets; and
- Require the Department of Rail and Public Transportation to make recommendations and supply technical assistance to service providers and localities regarding model transportation coordination methods and to develop and implement a standardized data collection system that can be used to determine the true cost of providing transportation services and measure the success of transportation coordination efforts.

With significantly more individuals with disabilities living in the community, their protection and support in the event of a disaster or other emergency is of growing importance, and **emergency preparedness and response planning** by the state and local governments has made progress since the Board’s 2008 assessment. Emphasizing individual preparedness, the Virginia Department of Emergency Management (VDEM) has taken steps to better prepare individuals with disabilities to shelter in place, providing related information to state disability agencies and making it available on their website. VDEM has also developed a uniform emergency preparedness template for use by localities to ensure that the needs of individuals are addressed in emergency preparation and planning activities. In developing the Commonwealth’s *Emergency Operations Plan* and in other planning activities, VDEM included disability services agencies as partners and formalized the roles and responsibilities of local and state disability services agencies in emergencies. The number of state-managed shelters across the state has expanded, and emergency exercises have included evaluators from disability services agencies.

The Department of Behavioral Health and Developmental Services (DBHDS) and the Department of Social Services (DSS) have revised their regulations to clarify the responsibilities of facilities and programs that they license in local emergency and evacuation planning, response, and evaluation. At this time, however, statewide monitoring and evaluation of these plans by those regulatory authorities to determine whether best practices have been adopted and identify deficiencies remain limited. The Board’s 2011 assessment further notes that significant improvements remain to be made by all state, regional, and local agencies responsible for responding to emergencies. Dissemination of information about the local availability of accessible shelters and accessible transportation in place for emergencies is especially lacking. The extent to which individuals with disabilities and their families are being involved in regional and local emergency planning and training activities is also not known.

In conclusion, the summary above and the more detailed information contained in the chapters on individual services of the 2011 *Assessment of the Disability Services System in Virginia* fulfill the Virginia Board for People with Disabilities' state and federal mandates as the Commonwealth's Developmental Disabilities Planning Council to provide a description of the disability services available statewide that are funded, operated, or licensed by the state. Development of this report would not have been possible without the extensive information and review provided by multiple state agencies. After review of this information and consideration of input provided by diverse stakeholders across the state, in keeping with its federally mandated role, the Board drafted the key findings and recommendations above to promote systems change, increase service capacity, and promote community integration for Virginians with disabilities.

Through these assessment recommendations, **the Board advocates for expansion and, in some cases, redesign of all disability services**, including those provided by contract, so that:

- ✓ Individuals with disabilities have access to and receive flexible, person-centered services and supports as needed for their lifespans;
- ✓ Supports are *front-loaded* to provide services as soon as indicated at appropriate levels;
- ✓ Individuals are served in inclusive, integrated community settings;
- ✓ Accountability exists for service quality and effectiveness that includes transparency through publication of agency and program funding, expectations, and actual outcomes;
- ✓ Meaningful, consistent oversight is provided to ensure service quality, timeliness, and appropriate outcomes; and
- ✓ State disability agencies have both the capacity and a mandate for identifying, collecting, analyzing, and publishing meaningful outcome data regarding programs or services.

State leadership can significantly transform services for Virginians with developmental and other disabilities by ensuring that these features exist in developing or expanding services.

II. Early Intervention

A. Introduction

Early intervention services target infants and toddlers, from birth until their third birthday, who are not developing as expected or who have a condition that can delay normal development. **When appropriate services and supports are made available as soon as possible to these infants and toddlers, significant long-term benefits for those children and their families result.** The need for special services later in life may be decreased or eliminated, and even if continued supports are needed, a child's opportunity to grow and develop to her or his full potential is enhanced.

Part C of the *Individuals with Disabilities Education Improvement Act* (IDEA, 20 USC 1431 *et seq.*), as amended in 2004, specifically defines "early intervention services" as those designed to meet the developmental needs of each child and the needs of the family related to enhancing the child's development and provided to children from birth to age three who have (i) a 25 percent developmental delay in one or more areas of development, (ii) atypical development, or (iii) a diagnosed physical or mental condition that has a high probability of resulting in a developmental delay. Referencing this definition, services authorized under IDEA are typically and interchangeably referred to as early intervention (EI) or "Part C" services and focus on increasing a child's ability to participate in family and community life. An "early intervention coordinator" works with the child and family to ensure identification of treatment needs, gather resources and information, and coordinate therapy and other intervention services. In Virginia, most early intervention services are provided through the **Infant and Toddler Connection of Virginia, Part C Office.**

Some Virginia children with disabilities also receive early intervention services through one of 18 **Early Head Start (EHS)** programs in geographic areas where those exist, under the authority of the *Head Start Act* of 2007 (42 USC 9801 *et seq.*). EHS programs serve low-income infants, toddlers, pregnant women, and their families. They are designed to enhance children's physical, social, emotional, and intellectual development; assist pregnant women in accessing comprehensive prenatal and postpartum care; support mothers' and fathers' efforts to fulfill their parental roles; and help parents move toward self-sufficiency.

A provider of Part C services since their inception in 1974, Virginia's efforts are guided by state statute (*Code of Virginia* 2.2-5300–5308). Eight state agencies share responsibility for providing Part C services through the **Virginia Interagency Coordinating Council** comprised of the Departments for the Blind and Vision Impaired and the Deaf and Hard of Hearing and the Departments of Education, Health, Social Services, Medical Assistance Services, and Behavioral Health and Developmental Services, as well as the Virginia Office for Protection and Advocacy. Of these, the **Department of Behavioral Health and Developmental Services (DBHDS)**, formerly the Department of Mental Health, Mental Retardation and Substance Abuse Services

(DMHMRSAS), is designated as the lead state agency accountable to the federal Office of Special Education Programs of the U.S. Department of Education for quality of service delivery and ensuring that Virginia's Part C services meet all applicable federal regulations and guidelines.

In 2008, there was significant discussion of changing Virginia's Part C state-level lead agency to the Department of Health from DMHMRSAS, as it was still called then. The October 2008 *Virginia Interagency Coordinating Council Retreat Summary Report* noted that Part C programs were housed in health departments in 40 states, a growing trend, and projected a number of benefits for children, their families, and providers if Virginia made the change. Under this initiative, Community Services Boards, partners with DMHMRSAS, would still have served as local lead agencies for Part C services.

Ultimately, it was determined to retain DMHMRSAS as Virginia's lead agency for Part C services, and a focus was placed on data system improvements and development of the **Medicaid Early Intervention Program**. Prior to this decision, DMHMRSAS was also identified as the agency that would coordinate autism services in Virginia. With the Part C program as a natural and appropriate component of the newly broadened range of services to be offered by DMHMRSAS, the agency was reconfigured and given its current name, the Department of Behavioral Health and Developmental Services (DBHDS).

With its role as lead agency reaffirmed, DBHDS has worked closely with its state agency and local partners to enhance the Part C program as a whole and improve early intervention services for infants and toddlers throughout Virginia. As noted in the 2008 edition of this *Assessment*, Part C Systems Transformation has been ongoing since 2007 and significant progress has been made. In coordination with a stakeholder group and Solutions Consulting Group, LLC, which published a key report and recommendations that year, DBHDS has identified four priorities for these improvements. From its November 2009 *Report on Virginia's Part C Early Intervention System* (Budget Item 316 K.21, 2009 *Appropriations Act*) to the General Assembly, those priorities are to:

- Develop and implement the Medicaid Early Intervention Initiative to expand Medicaid reimbursement for Part C early intervention services,
- Improve data systems to ensure the availability of accurate and complete data to address state and federal reporting requirements,
- Revise the funding formula by which federal and state Part C funds are allocated to local systems to ensure equity and parity, and
- Revise Virginia's family cost participation practices to ensure consistency statewide and to ensure that children and families are not denied services due to inability to contribute financially.

In addition to the identification of these priorities, significant training and technical assistance has been provided to professionals throughout the state. The federal Part C oversight

agency, the U.S. Department of Education's Office of Special Education Programs (OSEP), has recognized those improvements. After designating the Commonwealth in the "needs assistance" category for three years, OSEP's most recent determination letter, issued in Spring 2010, categorized the state's Part C system as "meets requirements."

Virginia's *Part C Annual Program Performance Report* for federal fiscal year 2008, the latest available report, details the progress that has been made toward the priority areas above and others. System improvement activities have included, but are not limited to, the following:

- Emergency regulations supporting changes in Medicaid reimbursement for Part C services went into effect on November 2009.
- A Service Pathway was developed to provide a visual representation of the flow of steps that take place as children and families move through the Part C system from referral to implementation. A Part C Practice Manual and new statewide forms were developed to support implementation of this Service Pathway.
- A Part C practitioner database was developed to track and manage provider certification and family choice of providers.
- DBHDS hired an autism specialist to work across agencies and with families and providers. Additionally, Communities of Practice in Autism (CoPA) training and advanced level training focused on strategies to support families with young children with autism spectrum disorders (ASDs) in natural environments was provided to 180 participants in six areas: Abingdon, Northern Virginia, Richmond, Roanoke, Tidewater and the Valley region.
- The Virginia Interagency Coordinating Council held a planning retreat to better determine its role in advising the lead state agency and in addressing issues and challenges identified through its work.
- Approximately 46,000 copies of Virginia's Part C developmental checklist brochure were included in New Parent Kits distributed through local departments of social services and other local agencies. Those materials are now available on the Smart Beginnings website as well.
- Statewide public awareness efforts continue and include radio spots, media kits, posters, and other materials, including strategies to reach traditionally underserved populations.

According to information provided by DBHDS and the Department of Medical Assistance Services (DMAS), Virginia was one of 19 states and territories selected to participate in the Assuring Better Child Health and Development (ABCD) Screening Academy. Individuals in leadership positions from DMAS, the Department of Health, and the Virginia Chapter of the American Academy of Pediatrics worked with stakeholders to increase the use of a standardized developmental screening tool by primary care providers as part of well child care. The goal was to identify and treat developmental concerns before a child reaches kindergarten, and as a result, program improvements were made.

In recent years, early intervention for infants and toddlers with autism spectrum disorders (ASDs) has received a great deal of long needed attention, and improvements in interventions have occurred. The lack of private insurance coverage for children with autism has also been a significant issue. (See Cost and Payment section of this chapter.) As mentioned above, there has been implementation of the Communities of Practice in Autism (CoPA) model in which practitioners shared information, resources, experiences, and best practices with their peers. Additionally, the Joint Legislative Audit and Review Commission's (JLARC) 2009 *Assessment of Services for Virginians with Autism Spectrum Disorders* (House Document #8, available at www.jlarc.virginia.gov) has served as a foundation for developing strategies and plans for better serving this population across the lifespan. The JLARC report presents a comprehensive review of the needs of individuals with ASDs as well as recommendations for development of a comprehensive system of services. Specific details can be found in the JLARC report and in the DBHDS response to it.

In the following description of Virginia's Part C and Head Start programs, please note that they operate on the federal fiscal year (FFY), October 1 through September 30; however some information is reported by state fiscal year (SFY), July 1 through June 30. The appropriate abbreviation, FFY or SFY, followed by the year is used to indicate which applies.

B. Eligibility for Early Intervention Services

Early Head Start: Eligibility for Head Start is income based, and federal poverty guidelines are used to evaluate family income. Early Head Start programs may also elect to target services to a particular population to best meet the unique needs of children and families in their community.

Statewide, Early Head Start programs must make at least ten percent of their enrollment opportunities available to children with disabilities who are eligible for Part C services under the *Individuals with Disabilities Education Improvement Act* (www.ehsnrc.org/ChildEligible.htm). According to data from the *Head Start Program Information Report* provided by the Virginia Department of Social Services Head Start Office, for FFY 2008, approximately 15 percent of the enrollees (238 of 1,592) in the state's Early Head Start programs during that year were children with disabilities receiving services under a Part C Individualized Family Services Plan (IFSP), exceeding the federal minimum. In FFY 2010, 37 percent more children were serviced by Early Head Start, however, only nine percent (195 of 2,175) received services under an IFPS, below the minimum requirement. No reasons for this decline in the proportion of children served under an IFPS were provided.

Part C Early Intervention: Every state develops its own definition of eligibility for Part C early intervention services. In the Commonwealth, as required in the *Code of Virginia* (2.2-5300), children from birth to age three (*i.e.*, until their third birthday) and their families are eligible for Part C services when a determination has been made that the child has:

- ✓ A developmental delay of at least 25 percent in one of the developmental domains of cognition, communication, motor, adaptive, or social/emotional; and/or

- ✓ Atypical development or behavior; and/or
- ✓ A diagnosed physical or mental disability that has a high probability of resulting in developmental delay (e.g., significant central nervous system anomaly, congenital or acquired hearing loss, chromosomal abnormalities, inborn errors of the metabolism, severe attachment disorders, autism spectrum disorder, and brain or spinal cord trauma).

More detailed information on how these are assessed can be found in the Virginia Part C Policies and Procedures for Part C of the *Individuals with Disabilities Education Improvement Act* (IDEA) at www.infantva.org/documents/ovw-PGuideStateDefinition.pdf. A complete list of eligible conditions can be found at www.infantva.org/documents/pr-PM-PracticeManual.pdf.

Part C services are available to all eligible children regardless of their families' ability to pay. (See Cost and Payment section of this chapter.) Eligibility for Part C is determined by a multidisciplinary team at the local **Infant and Toddler Connection** system. As recently as 2008, some children referred to Part C were "screened out" prior to receiving a multidisciplinary team evaluation of their eligibility, but that process has changed.

The Part C program now requires that, with parental consent, all referred children receive a developmental screening using a screening tool unless there is (1) a diagnosed physical or mental condition with a high probability of resulting in developmental delay, (2) documented developmental delay or atypical development; or (3) the child has already received a developmental assessment or screening prior to referral. Unless the parent refuses to proceed to an eligibility determination all children receive a multidisciplinary evaluation to determine eligibility. This includes a multidisciplinary team review of medical reports, developmental screening results, parent reports, observations summaries, and assessment reports, if any. The team then determines if eligibility criteria are met. These changes described in the 2008 *Part C Annual Program Performance Report* are designed to ensure accurate and timely eligibility determinations. The process was a collaborative effort between Department of Behavioral Health and Developmental Services and the Department of Medical Assistance Services.

C. Access to and Delivery of Early Intervention Services

Early Head Start: According to the Virginia Department of Social Services' Head Start Office, 18 of the 48 Head Start grantees in Virginia during FFY 2010 provided Early Head Start, thus limiting access to this program by geographic availability. (Two of the grantees provided only Early Head Start.) This was an increase of seven Early Head Start programs since the 2008 program year. Families can determine if a program exists in their area using the Head Start locator at <http://eclkc.ohs.acf.hhs.gov/hslc/HeadStartOffices#map-home>.

Federal regulation 45 CFR 1308.4 requires each Early Head Start program to develop a Disabilities Service Plan to ensure the needs of children with disabilities and their families are met. This plan must be updated annually and include the following components:

- Provisions for children with disabilities to be included in the full range of activities and services normally provided to all Head Start children and provisions for any modifications necessary to meet the special needs of the children with disabilities;
- The need for small group activities, modifications of large group activities, and individualized special help;
- Designation of a disabilities coordinator and arrangement for the preparation of disability service plans;
- Procedures for timely screening and making referrals to the local education agency to determine if there is a need for special education and related services for a child as early as the child's third birthday;
- Assurances that facilities are accessible along with plans to provide any needed specialized furniture, equipment, and other materials; and
- Strategies to ensure the transition of children from Early Head Start (ages 0-3) into Head Start (ages 3-5) or into their next placement.

The *Head Start Act* of 2007 requires formal linkages with providers of early intervention services for infants and toddlers with disabilities as established in Part C of the *Individuals with Disabilities Education Improvement Act* (IDEA) and with the agency responsible for administering section 106 of the *Child Abuse Prevention and Treatment Act* (42 USC 5101 *et seq.*, 42 USC 5116 *et seq.*).

Part C Early Intervention: As the state lead agency for Part C services (*Code of Virginia* 2.2-5304), the **Department of Behavioral Health and Developmental Services (DBHDS)** is responsible for supervising and monitoring Virginia's Part C early intervention system and for ensuring both the quality of service delivery and compliance with federal regulations. Through its **Office of Child and Family Services**, DBHDS establishes regulations and adopts statewide policies and procedures to ensure consistent and equitable access to Part C services. It also manages the statewide interagency system that coordinates early intervention services. The resulting Part C system emphasizes local decision-making and autonomy in service implementation with state-level accountability for consistency in quality and availability of services.

Virginia's Part C system is further designed to accentuate understanding by the professional and lay communities of the wide range of developmental delays and disabilities encountered in early childhood, the recognition of the benefits of early identification and response, and the importance of a team approach focusing on the individual needs of each child and family. Local geography, service availability, populations and political jurisdictions served,

and organizational structure are among the variables of local systems. In some areas, personnel shortages contribute to a wide variability in services between localities.

In administering the system, DBHDS currently contracts with 40 local lead agencies, local **Infant and Toddler Connection** programs, which are designated by local city or county governments. Currently, 30 Community Services Boards (CSBs) serve as local lead agencies for Part C services. Lead agencies for the remaining localities include two local education agencies, four universities, two health departments, and two local governments. The local lead agency is required to designate a single point of entry for the local system, which is usually itself.

Local lead agencies are responsible for budget management, federal and state Part C fund allocation, data collection and reporting, and conducting **Child Find** activities. Child Find, a federal mandate under the *Individuals with Disabilities Education Improvement Act* (IDEA), requires that the local lead agencies identify infants and toddlers who may be eligible for Part C services and conduct public awareness campaigns that encourage referrals to and use of the early intervention system.

Service delivery is also the responsibility of local lead agencies, and they have flexibility in its administration. Some provide Part C services directly through their agencies, some contract for direct services, and others do both. Local lead agencies determine eligibility and provide service coordinators (case managers) who guide families through the early intervention process and facilitate the development and implementation of required **Individualized Family Services Plans (IFSP)**. An IFSP lists the outcomes that the family and Part C team would like to see for the child and identifies the services and supports needed to meet those outcomes. Family participation is a fundamental part of the IFSP process, ensuring that it corresponds to their resources, concerns, and priorities.

Referrals to the Part C system can come from a variety of sources, including “self-referral” by a family, but referrals for evaluations and Part C services do not require the consent of a child’s parents or legal guardians. All families referred to Part C are eligible to receive a multidisciplinary evaluation to determine their children’s eligibility for services.

In comparing referral data over time, the 2007 *System of Payments Summary Report* by Solutions Consulting Group found that, in SFY 2006, 39 percent of referrals came from physicians, 12 percent came from hospitals; 23 percent came from parents or guardians, and three percent came from friends, neighbors, and relatives. Similar data from the DBHDS Infant and Toddler Online Tracking System (ITOTS) for SFY 2010, shows referrals from physicians (45 percent) and parents and guardians (22 percent) to be stable with an expansion of referrals from other sources: six percent from the Department of Social Services and about two percent each from the Department of Health, Community Services Boards, and the category of Friends/Neighbors/Relatives.

Annual data on the unduplicated number of infants and toddlers receiving Part C services is calculated two ways. Each year, DBHDS produces a “point-in-time” count by tallying the

number of individual children being served on the same day, December 1, to produce the “December Child Count.” It is important to note that this count does not reflect all children served throughout the year. The total unduplicated count of infants and toddlers who are served over the course of the state fiscal year (SFY, July 1 to June 30) is referred to as the “Annualized Count” (previously known as the “Aggregate Count”). The table below depicts both counts for the past five years.

NUMBER OF INFANTS AND TODDLERS ELIGIBLE AND ENTERED PART C SERVICES

Type of Count	2006	2007	2008	2009	2010
December Child Count	4,619	6,023	6,321	6,288	7,378
Annualized Count	10,212	10,330	11,351	11,766	13,421

Sources: December Child Count: ITOTS database reports provided by DBHDS on August 2, 2010 and February 1, 2011. Annualized Count: DBHDS: *Report on Virginia’s Part C Early Intervention System* (Budget Items 312 K.2, 312 K.2, 316 K.2, 316 K.2, and 305 H.2., 2006-2010 Appropriations Acts, respectively).

The number of children receiving Part C services is trending upward. The overall increase in the Annualized Count from 2006 to 2010 was 30 percent, with an increase of 14 percent from 2009 to 2010, following a relatively stable 3.5 percent increase from 2008 to 2009. From 2006 to 2010, the December Child Count increased by nearly 60 percent, with a 17 percent increase over just the last year. It will be important to note future trends. While DBHDS has not analyzed why the numbers increased so significantly from 2009 to 2010, it can be presumed that some of the increase was due to the implementation of the new Medicaid Early Intervention Program. The temporary infusion of federal *American Recovery and Reinvestment Act* (ARRA) stimulus funds may also have been a factor.

DBHDS continues to work with its local partners to improve the Part C program and services for infants and toddlers throughout the state. The following table reflects data now being collected to track an important statistic, the proportion of infants and toddlers who were referred for but are not known to have received services.

NUMBER OF INFANTS AND TODDLERS EVALUATED BUT DID NOT ENTER SERVICES

Federal Fiscal Year (FFY)	2006	2007	2008	2009	2010
Did not Enter Services			1,760	1,671	1,494
Eligible and Entered Services	10,212	10,330	11,351	11,766	12,234

Sources: DBHDS: *Annual Report on Virginia’s Part C Early Intervention System* for 2008, 2009, and 2010

Comparable data is not available for FFY 2006 and 2007, but for FFY 2008, 13.4 percent (1,760) of a total of 13,111 infants and toddlers determined by evaluations to need Part C services are not known to have moved forward to receive them. The proportion dropped to 12.4 percent (1,671 of 13,347) in FFY 2009 and even further in FFY 2010 to 10.9 percent (1,494 of 13,720). These children all received a multidisciplinary team evaluation and assessment, but they were found to be ineligible for Part C, services were declined, or they were lost to contact.

Although Virginia is improving with respect to the number of infants and toddlers served overall, the Commonwealth continues to be less successful than other states in its identification of those needing services. DBHDS set a target for FFY 2008 of serving 0.77 percent of infants and toddlers birth to one year who may have a developmental delay or a disability likely to result in a developmental delay and be in need of services. According to the FFY 2008 *Part C State Annual Performance Report (APR)*, the last report submitted, the December Child Count showed that Virginia actually served 0.67 percent. The comparable figure at the national level was 1.04 percent. Of the 39 local Part C systems in FFY 2008, 15 met the 0.77 percent target, and two were within 95 to 99 percent of reaching it. Twenty-two local systems reached only 42 to 86 percent of the target. All local systems were notified of their need to improve performance, and the 22 local systems that met less than 93 percent of the target were required to develop a Service Enhancement Plan. Specific strategies undertaken to correct deficiencies can be found in the 2008 APR.

The number of systems not achieving the target in FY 2008 was an increase over FFY 2007 when only 18 local systems did not reach that year's target. The FFY 2008 APR noted that this slippage was in part due to budget constraints, citing that funding and personnel that would normally have been available for public awareness and Child Find efforts were redirected to ensure that direct services and supports were available to eligible children. It is expected that the Medicaid Early Intervention Program will continue to help increase revenue to the Part C system, freeing funds for enhanced awareness and Child Find.

The *Part C State Performance Plan for 2005-2010*, amended in February 2010, set the target for serving the birth to age one population at 0.87 percent for FFY 2009. Data on whether this target was achieved will not be known until publication of the next APR. Data on the birth to one population were not included in the October 2010 *Part C Annual Report to the General Assembly* (Budget Item 305 H.2., 2010 *Appropriations Act*).

With respect to serving the birth to age three population, a target of 2.1 percent was set for FFY 2007 and a 2.6 percent target was set for FFY 2008. Neither target was met. The 2008 December Child Count showed that Virginia served 1.99 percent vs. 2.66 percent served under Part C nationally. The 2008 APR reported that 20 local systems met the FFY 2008 target, five substantially met the target, and 14 did not, serving between 52 and 93 percent of the target. The statewide percent served remained unchanged in the 2009 December Child Count, but there has been slight improvement from FY 2007 when the percent served was 1.92 percent. As above for the birth to age one population, systems that did not meet the target were required to develop a Service Enhancement Plan, and the APR noted that budget constraints contributed to less than expected progress because money for Child Find and public awareness were redirected to direct services.

Virginia has also been cited for a lack of proportionality between the number of infants and toddlers served by its Part C system and related state spending. In a presentation before the Virginia Interagency Coordinating Council on September 12, 2007, the authors of the *System of Payments Summary Report*, Solutions Consulting Group, stated "The infusion of new state funds

has had little impact on the number of children in service using the point in time count.” Following this, in its 2008 *Report on Virginia’s Part C Early Intervention System* to the General Assembly, DBHDS indicated that the disproportionate growth in state funding compared to numbers served could stem from higher costs for serving children in natural environments, including the rising cost of gasoline, a higher intensity of services required for children with more significant disabilities such as autism, lower local contributions toward the total cost of Part C services as state funding has increased, or other causes still to be determined. DBHDS staff track this data and have recognized and supported the need for further review of Part C expenditures that would include an assessment of whether sufficient funds are being directed to Child Find. Efforts in this area remain underway, and the 2010 Part C report to the General Assembly did not address this specific issue.

The trend in infants and toddlers served, however, has been slowly upward. The number of children served increased by four percent from FFY 2009 to FFY 2010, and it is anticipated that it will increase further with the Medicaid Early Intervention Program.

In August 2010, DBHDS convened a new workgroup to focus on Early Intervention Prematurity. The minutes of this meeting identify the following goals that will be considered at further meetings scheduled into the spring of 2011:

- Determining how to identify which premature infants should be referred to early intervention and when,
- Ensuring providers are able to identify children who may be eligible and provide the appropriate education and supports to children and families,
- Decreasing (eliminating) the number of children who fall through the cracks,
- Developing a better system for identifying premature babies who may be in need of services and reaching their families, and
- Improving collaboration with Neonatal Intensive Care Units (NICUs), including improving the transition process from the NICU to home and community based services.

Efforts such as these are reflected in the October 2010 *Report on Virginia’s Part C Early Intervention System* which notes that DBHDS is exploring the potential impact on children and the Part C system of eliminating the current policy of “age adjustment” for children born prematurely and examining other aspects of eligibility to ensure that children are identified accurately and as early as possible.

D. Available Early Intervention Services

Early Head Start: As reported in the Virginia Head Start Association’s 2008-2009 *Annual Report*, the last report available, the mission of Early Head Start is to promote healthy prenatal outcomes for pregnant women, enhance early childhood development, and promote healthy

family functioning. It is a family oriented program that provides guidance information and direct services.

Direct and indirect (referral) services for infants and toddlers enrolled in Early Head Start in Virginia include early education, medical, and dental services and family supports. The Head Start grantee or the agency delegated by the grantee to deliver Head Start services is responsible for coordinating with the Part C local lead agency with respect to serving children with disabilities eligible for both programs. As previously noted, infants and toddlers with disabilities receive all of the services specified by their Individualized Family Services Plan (IFSP) as well as standard Early Head Start services. The IFSP specifies which services are to be provided directly by Head Start and which will be provided by other agencies. As provided for in federal Head Start regulations, IFSP services may include, but are not limited to: audiology, physical and occupational therapy, speech and language services, psychological services, assistive technology, and transportation.

Part C Early Intervention: The Commonwealth's early intervention system, as described by Virginia's Part C Office, envisions an optimum that may or may not occur in practice, particularly with extensive variability in local systems, provider capacity, and funding. Services are based on current research and best practices that emphasize empowering parents and strengthening their abilities to meet the developmental needs of their children, encouraging consistency of intervention, and avoiding over-utilization of therapy. Parents and service providers become partners, working closely together to make the most effective use of learning opportunities and other activities that arise normally throughout the child's and its family's daily routine. The frequency, structure, and level of services are designed to fit each individual family's schedule, environment, and needs for support. Support coordinators facilitate access to and timely delivery of Part C and other clinical and support services and monitor the evolving needs of the family and child over time.

The foundation for these Part C services is the **Individualized Family Services Plan (IFSP)** and subsequent follow-up that emphasizes a holistic and seamless approach that brings together medical, developmental, psychosocial, and educational resources to ensure that the comprehensive needs of the child and family are met most effectively. Frequency and intensity of IFSP activities are adjusted as the child's and family's needs for support and guidance changes. Individual components of the plan may include:

Assistive technology	Occupational therapy
Audiology	Physical therapy
Developmental services	Psychological services
(previously called specialized instruction)	Respite care
Family training, counseling and home visits	Social work services
Health services	Speech/language pathology
Medical diagnostic and evaluation services	Transportation
Nursing and nutrition services	Vision services

In order to increase family's participation in their children's therapies and to provide continuity and consistency in service delivery, federal regulations stipulate that early intervention services must be provided in "natural environments" that meet the needs of the child to the maximum extent possible. Natural environments are defined as the home and other community settings that include children without disabilities and that are normal for the child's same-age peers. The provision of services in other settings is deemed appropriate only if outcomes cannot be achieved in natural environments.

A key component of an IFSP addresses a child's transition from services under the Part C early intervention portion of the *Individuals with Disabilities Education Improvement Act* (IDEA) to the Part B special education portion of that act or to other community services, if needed. Family planning and preparation for transition from Part C to Part B services include training parents on timelines, future placement options, and other matters; transmission, with the parents' consent, of information about the child to the local educational agency; and preparing the child to adjust to changes in service delivery.

Federal regulations under IDEA require that states have policies and procedures on file with the U.S. Department of Education that ensure a smooth and effective transition between Part C programs and Part B preschool programs. Public schools must participate in transition planning with Part C local lead agencies, and an **Individualized Education Program (IEP)** must be developed and implemented for each child receiving Part C services before his or her third birthday if that child requires special education services under Part B.

Virginia is the only state that makes Part B services available to children ages 24 to 36 months, creating a potential for overlap between the Part C early intervention and Part B special education systems. Since a child cannot receive Part C and Part B services concurrently, parents must decide whether the child will remain in the early intervention system during this period or make an early transition to the special education system. Information on Part B special education eligibility and services is covered in the Education chapter of this report.

The chart below shows the estimated number of children who received various types of early intervention services for state fiscal years (SFY) 2007 to 2010. The significant differences for some services between SFY 2010 and previous years are due at least in part to differences in how the counts were derived. In SFY 2010, some of the services were reported under different names that may not exactly replicate the services reported in previous years. Other differences relate to changes in data collection and estimation processes.

PART C EARLY INTERVENTION SERVICES LISTED ON INITIAL IFSPs

	SFY 2007	2008	2009	2010
Assistive Technology	72	204	188	196
Audiology	258	341	318	12
Counseling*	52	79	35	184
Developmental Services**	2,407	2,542	2,200	2,484
Initial Evaluation/Assessment	6,768	7,811	7,609	9,296
Health Services	2	2	0	4
Medical Services (for evaluation/diagnosis)	8	11	4	<i>not reported</i>
Nursing Services	4	2	0	24
Nutrition Services	21	68	71	86
Occupational Therapy	1,498	1,862	1,600	1,248
Physical Therapy	2,965	3,950	3,236	2,068
Psychological Services	12	2	0	0
Service Coordination	10,3330	11,351	11,766	12,234
Social Work Services	93	125	106	6
Speech-Language Pathology	4,855	4,801	4,177	3,132
Transportation	6	5	2	281
Vision Services	83	148	129	49
Other Entitled Early Intervention Services	62	68	71	***2,083

* Counseling was formerly reported as Family Training and Counseling.

** Developmental Services were formerly called and reported on as Special Instruction.

*** DBHDS reports that the significant increase from previous years in the final category, Other Entitled Early Intervention Services, occurred because of a change in the SFY 2010 reporting form. The change to the form eliminated the option of reporting aggregate expenses for local systems whose accounting did not allow identification of the specific services purchased. The increase, therefore, most likely represents the use of the Other Entitled Early Intervention Services category to capture what were formerly called aggregate expenses for direct services rather than an actual increase in Other Entitled Early Intervention Services.

Sources: DBHDS: *Report on Virginia's Part C Early Intervention System* (Budget Items 312 K.2, 312 K.2, 316 K.2, 316 K.2, and 305 H.2., 2006-2010 *Appropriations Acts*, respectively).

Prior to SFY 2010, the DBHDS data system captured only the planned services identified on a child's initial IFSP. It did not update with services added on subsequent IFSPs or represent services actually delivered, which can be quite different than those listed on an initial IFSP. In addition, the Part C data system previously only provided information on children included in the annual December Child Count. To obtain the estimated count for a service for all children for a state fiscal year, the percentage of children in the Part C system on December 1 whose initial IFSP included a service was applied to the Annualized Count of children receiving services throughout the year. This method also overestimated some services, such as audiology, that might be used only for screening purposes.

Beginning in SFY 2010, DBHDS instituted a new system requiring both local lead agencies and private providers to report the number of children actually receiving each service in

each quarter. Based on questions related to the changes in its reporting forms, DBHDS determined that there may have been problems with the accuracy of data regarding the number of children served during the first two quarters of SFY 2010. As a result of these concerns and to account for duplication across multiple quarters, the total number of children receiving each service in the fourth quarter was then used to estimate the total for the full fiscal year. DBHDS notes that this estimate was more accurate than in previous years because the data is now based on actual services delivered rather than initial or planned services. Reservations expressed in the October 2010 *Report on Virginia's Part C Early Intervention System* (Budget Item 305 H.2, 2010 *Appropriations Act*) about the reliability of data reported by local lead agencies remain, however, as there is still no mechanism for determining its accuracy.

E. Cost and Payment for Early Intervention Services

This section provides information on the varied public funding sources and expenditures for the Part C services system statewide. Following this information, a brief overview of health insurance resources, both private and public, is provided.

Early Head Start: In Virginia, Head Start programs greatly outnumber Early Head Start programs (46 to 18, respectively), and reports do not differentiate allocations or expenditures between the two; therefore, expenditure information will be covered under Head Start in the Education chapter of this assessment.

Part C Early Intervention: As the state's lead agency, the Department of Behavioral Health and Developmental Services (DBHDS) manages the budget of Virginia's Part C early intervention system. Children and families determined eligible for Part C services are entitled to receive those services, but not all Part C services are provided free of charge, and fees may be charged in accordance with state law. Regulations 34 CFR 303.522 (a)(1) and 34 CFR 303.527 governing expenditures of funds under Part C of the *Individuals with Disabilities Education Improvement Act* (IDEA) specify that they may be expended only after other sources, such as public (Medicaid, etc.) and private insurance, donations, and fees based on a family's ability to pay, have been applied.

Virginia's annual allocation from the federal government to support Part C services is proportional based on comparison of the state's population from birth to three with the national total for those ages. This allocation had been fairly stable over many years until it was increased by nearly a million dollars in federal fiscal year (FFY) 2008. Significant economic challenges since then, however, resulted in reductions of over \$100,000 in FFY 2009 and nearly \$700,000 in FFY 2010. The result was smaller allocations by the state to localities in FFY 2009, mitigated in FFY2010 by an infusion of stimulus funds and thus increased financial stability through FFY 2011. The federal allocation for direct services for the last five years are as follows:

PART C FEDERAL FUND ALLOCATIONS FOR DIRECT SERVICES

Federal Fiscal Year	Allocation
2006	\$8,419,704
2007	8,839,815
2008	9,881,918
2009	9,782,026
2010	\$9,087,761

Sources: DBHDS: *Report on Virginia's Part C Early Intervention System* (Budget Items 312 K.2, 312 K.2, 316 K.2, 316 K.2, and 305 H.2., 2006-2010 *Appropriations Acts*, respectively).

As indicated, the amounts listed above represent only the federal allocations for direct services. Total federal allocations are higher and include funds expended on state and local infrastructure costs. The Virginia General Assembly also allocates state General Funds to support Part C services, and while the *Code of Virginia* does not mandate that localities provide funding for any costs under the Part C system, localities are involved in identifying alternative funding sources. Among others, local contributors of cash and in-kind support include Community Services Boards, health departments, and schools, as well as the Part C local lead agencies themselves.

Despite declines over the past two years, significant progress had been made with respect to increasing the amount of state funding for Part C services. Unfortunately, however, this improvement in state funding has been accompanied by a decrease in localities opting to provide local funding. Combined with significant budget shortfalls due to the nation's economic challenges, the Part C program, like others, has suffered in terms of adequate funding. The state General Fund appropriations shown below must be used for direct services.

PART C STATE GENERAL FUND ALLOCATIONS

State Fiscal Year	Allocation
2006	\$3,125,000
2007	7,203,365
2008	7,203,365
2009	7,104,850
2010	\$6,861,337

Sources: DBHDS: *Report on Virginia's Part C Early Intervention System* (Budget Items 312 K.2, 312 K.2, 316 K.2, 316 K.2, and 305 H.2., 2006-2010 *Appropriations Acts*, respectively).

In October 2010, DBHDS released its annual *Report on Virginia's Part C Early Intervention System* (Budget Item 305 H.2., 2010 *Appropriations Act*) for the state fiscal year ending June 30, 2010. This report notes that the fiscal climate for Part C has improved as a result of increased Medicaid revenue following the implementation of the Medicaid Early Intervention Initiative and the availability of over three million dollars in federal stimulus funding under the *American Recovery and Reinvestment Act* (ARRA). It further notes that the fiscal outlook for SFY 2011 remains positive due to these continuing funding infusions. ARRA

funding, however, ends on September 30, 2011, and there remains a need to closely monitor revenue and expenditure data and to identify the amount and sources of funding that will be needed to ensure the Part C program's long-term financial stability.

The table below summarizes all revenue sources for Virginia's Part C system, as reported by the 40 local lead agencies for the last four state fiscal years (SFY):

AMOUNT AND SOURCE OF PART C REVENUES, STATE FISCAL YEARS 2007-2010

Revenue Source	SFY 2007	2008	2009	2010
Federal Part C Funds	\$8,839,815	\$9,881,918	\$9,782,026	\$9,087,761
State Part C Funds	7,203,365	7,203,365	7,104,850	6,861,337
Federal ARRA Funds	(not applicable)	(not applicable)	555,107	4,301,650
Local Funds	7,427,535	8,370,228	8,131,851	7,727,982
Family Fees	367,346	322,915	358,611	485,983
Medicaid	1,081,489	1,095,727	1,486,253	3,656,354
Targeted Case Management	971,609	1,538,804	1,948,032	2,576,568
Private Insurance	825,931	1,049,697	1,052,112	2,512,116
Grants/Gifts/Donations	304,412	293,697	371,286	22,668
Other	1,008,074	624,754	1,424,765	2,800,611
Local Report of Aggregated Non-Part C Revenue	2,623,750	2,066,283	5,276,318	(not applicable)
In-Kind	(not applicable)	(not applicable)	(not applicable)	210,504
TOTAL	\$30,653,326	\$32,447,388	\$37,491,211	\$40,243,534

Sources: DBHDS: *Report on Virginia's Part C Early Intervention System* (Budget Items 312 K.2, 316 K.2, 316 K.2, and 305 H.2., 2007-2010 Appropriations Acts, respectively).

As noted previously in the table under Available Early Intervention Services, beginning in SFY 2010, aggregate expenses that do not identify specific services can no longer be reported. In a positive step toward greater clarity and accountability, all expenses must be attributed to a service category. This change is just one outcome of the doubling of resources dedicated to improving tracking of revenues and expenditures between SFY 2007 and 2010. Further information on the steps being taken by DBHDS to improve its data systems is detailed in the Monitoring and Evaluation section of this chapter.

Costs related to administration, system management, data collection, and training totaled \$1,962,120 in SFY 2007; \$2,097,160 in SFY 2008; \$2,139,927 in SFY 2009; and \$5,816,344 in SFY 2010. According to DBHDS, the substantial increase in SFY 2010 reflects the expenditure of ARRA funds for one-time costs related to improved data collection and related training. It should also be noted that some Part C revenues, such as local funds, may be used for expenses other than direct services and, therefore, are not reflected in the data showing expenditures for direct services.

Virginia's Part C program's expenditures exceeded revenues by \$1,168,969 in SFY 2008 and by nearly double that amount, \$2,196,942, in SFY 2009. A carryover of unspent federal and state Part C funds from SFY 2007 was used to offset the SFY 2008 shortfall. Then, according to the 2009 *Report on Virginia's Part C Early Intervention System*, this enabled SFY 2008 to end with \$1 million in unspent funds which were applied to the SFY 2009 shortfall. That year, in addition, a number of providers agreed to lower their rates to ensure continued service to families.

The infusion of federal stimulus (ARRA) funds and the implementation of the Medicaid Early Intervention Program in SFY 2010 eliminated the deficit. As shown in the table above, Medicaid revenue increased from just under \$1.5 million in SFY 2009 to more than \$3.6 million in SFY 2010. Medicaid revenue is expected to further increase in SFY 2011, which will expand the availability of federal and state funds as payer of last resort for services for children without insurance and for services not covered by private insurance.

The next table lists service expenditures for each category of Part C direct services for SFY 2007 through 2010.

PART C DIRECT SERVICE EXPENDITURES BY CATEGORY, STATE FISCAL YEARS 2007-2010

Expenditure	SFY 2007	2008	2009	2010
Assessment for Service Planning				\$2,112,026
Assistive Technology	\$34,629	\$44,475	\$92,554	\$64,222
Audiology	12,691	14,496	8,533	8,239
Counseling*	50,097	97,339	89,164	183,757
Developmental Services**	1,810,959	2,277,328	2,319,073	3,514,105
Evaluation and Assessment	840,445	992,858	909,382	370,422
Health	3,290	500	4,220	32,426
Nursing	1,599	500	500	498
Nutrition	1,733	1,035	734	57,461
Occupational therapy	903,419	1,157,256	1,060,017	3,011,633
Physical therapy	1,623,660	1,947,473	1,812,654	4,062,847
Psychology	1,500	2,000	4,372	0
Service coordination	4,238,341	5,295,426	4,852,787	8,552,563
Social work	62,567	13,160	6,600	17,579
Speech/language pathology	2,195,039	3,187,203	2,980,410	8,143,435
Transportation	68,906	49,864	36,575	19,200
Vision	42,627	32,240	77,818	20,912
Other Entitled Part C Services	403,555	452,236	315,352	1,404,581
ARRA Funds for Services			535,771	
TOTAL	\$12,295,057	\$15,565,389	\$15,106,516	\$31,575,906

* Counseling was formerly reported as Family Training and Counseling.

** Developmental Services were formerly called and reported on as Special Instruction.

Sources: DBHDS: *Report on Virginia's Part C Early Intervention System* (Budget Items 312 K.2, 316 K.2, 316 K.2, and 305 H.2., 2007-2010 *Appropriations Acts*, respectively).

In reviewing the table above, it is important to note that the sources and labeling of data are not consistent for all years. Local systems that received ARRA funds in SFY 2009 were not required to report on their use until October 2009, after the close of the federal fiscal year (FFY), too late to be included in the report for the state fiscal year (SFY) which closed at the end of June. One system, however, did include its expenditure of ARRA funds by service category in its SFY 2009 report. The remaining SFY 2009 ARRA expenditures by the other systems are listed separately at the end of the list. Information specific to ARRA funds was not reported in SFY 2010, and a new category, Assessment for Service Planning, was added. Improved data collection efforts by DBHDS also resulted in an increase in the number of reports by private providers from five in SFY 2009 to 54 in SFY 2010.

Total expenditures rose 156.8 percent from SFY 2007 to SFY 2010. The largest increases were for assistive technology, counseling, developmental services, health, nutrition, occupational and physical therapies, services coordination, and speech/language pathology. Significant differences in annual spending distributions can also be seen; however, while comparisons can be made among SFY 2007 through SFY 2009, the changes seen in SFY 2010 cannot be compared with earlier years because of programmatic changes to the system. For example, nutrition expenditures increased significantly in SFY 2010 because this is now a Medicaid covered service through the Medicaid Early Intervention Program.

Public Health Insurance: For many families of children with disabilities, public health insurance is a critical benefit that provides access to needed services. Basic information on eligibility, coverage, and administration for Virginia's public health insurance plans can be found in the Medicaid chapter of this assessment. Specific elements of these plans of particular relevance to the provision of early intervention services for infants and toddlers are covered below.

The state's **Medicaid FAMIS Plus** program provides coverage for **early and periodic screening, diagnosis, and treatment (EPSDT)** for children determined to be eligible for Medicaid. This includes children eligible for Medicaid as a result of receiving services under one of the Home and Community Based Services (HCBS) Waivers described in this assessment's Community Supports chapter. EPSDT services are intended to help ensure that a child's health problems are diagnosed and treated early before they become more complex and their treatment becomes more costly. EPSDT provides comprehensive coverage including assessment/diagnosis and the medically necessary services that are required to correct an identified condition, ameliorate its effects, prevent it from worsening, or prevent the development of secondary conditions. In the past, EPSDT was an underutilized funding source for Part C services; however, Medicaid eligible children can now access Part C services through the Medicaid Early Intervention Program.

Families not eligible for Medicaid FAMIS Plus may qualify for coverage under the state's Children's Health Insurance Program (CHIP), which in Virginia is known as the **Family Access to Medical Insurance Security (FAMIS)** program. Coverage under this plan is similar, but not identical, to that provided by FAMIS Plus. In addition to medical, vision, and dental

coverage, medically necessary services such as speech/language, physical, and occupational therapies and durable medical equipment are covered. Nursing and personal assistance services may also be covered. Some services are covered in full, while others may require copayments.

The Commonwealth's new **Medicaid Early Intervention Program** was established through its Part C Systems Transformation initiative and is now the only way for Virginia families to access funding for most Part C services under Medicaid. A 2009 joint presentation by the Department of Medical Assistance Services (DMAS) and the Department of Behavioral Health and Developmental Services (DBHDS), entitled "Early Intervention Services," noted that prior to the transformation initiative, DMAS was not able to identify children enrolled in early intervention services because providers billed using reimbursement codes for particular therapy services (such as physical therapy, occupational therapy, etc.). The same held true for children being serviced through Medicaid managed care organizations (MCOs) In addition, DMAS neither reimbursed for all costs associated with providing services in natural environments (although it had been a federal requirement) nor reimbursed for all types of providers who could deliver early intervention services consistent with Part C regulations.

Priorities identified for the Part C System Transformation, and the process by which they were developed, were detailed in the Introduction to this chapter. The anticipated results of their implementation were (1) a more stable and equitable funding structure for Part C services, (2) compliance with federal fiscal requirements and assurances, (3) reimbursement for effective practices (teaming, consultation, and service provision in natural settings), and (4) improved provider recruitment and retention.

With these priorities and anticipated results in mind, the Medicaid Early Intervention Program was implemented on October 1, 2009. The October 2010 *Report on the Part C Early Intervention System* (Budget Item 305 H.2, 2010 *Appropriations Act*) lists the following initial outcomes:

- DMAS funded early intervention services are now available to children eligible for FAMIS or FAMIS Plus after eligibility screening through those programs.
- Reimbursement rates were increased for physical and occupational therapy and speech/language pathology services.
- Medicaid coverage was added for developmental, counseling, nursing, psychological, and social work services provided in accordance with a child's Individualized Family Services Plan (IFSP).
- Personnel are required to meet discipline-specific qualifications and individual practitioners other than physicians, audiologists, and registered dietitians must be certified by DBHDS as either an early intervention professional, specialist, or service coordinator.

- Standard rates were established for early intervention services to be used statewide regardless of reimbursement source in order to ensure equity and parity across local systems and maximize use of available funding.
- A rate structure consistent with Part C service delivery requirements and effective practices was established. For example, rates now take into account travel costs associated with providing services (as federally required) in the child's natural environment and support routine consultation and teaming among service providers. They are also more competitive with other service delivery systems in order to facilitate recruitment and retention of providers, a concern which has been cited in previous editions of this assessment.

To address reimbursement and other issues related to implementation of the Medicaid Early Intervention Program, DMAS submitted State Plan Amendment (SPA) 09-20 Part C Early Intervention Services) to the federal Centers for Medicare and Medicaid Services (CMS), which approved the amendment on August 10, 2010. This amendment enables reimbursements for Part C services under certain Medicaid categories, such as audiology under medical services for evaluation purposes, nutrition under Medicaid's outpatient rehabilitation program, and assistive technology as durable medical equipment.

The number of approved providers has continued to grow since the program's implementation. According to the October 2010 Part C report, there were 1,165 certified early intervention professionals, specialists, and service coordinators in Virginia. This was a 22 percent increase from the 956 reported in the December 2009 DBHDS System Transformation Update.

Both the number and proportion of children receiving Part C services enrolled in the Medicaid Early Intervention Program also continue to grow. The minutes of the December 2009 meeting of the Virginia Interagency Coordinating Council (VICC) reported 2,830 children, representing approximately 40 percent of children receiving Part C services, were enrolled in the program. More recently, VICC reported that on July 1, 2010, there were 3,216 children enrolled in the program, constituting 51 percent of the 6,302 children receiving services under Part C.

In its October 2010 Part C report, DBHDS identifies the need to change way in which federal and state Part C funds are allocated to local systems in order to ensure the stability of the Part C funding structure. The change would account for local systems that have a higher population of children dually enrolled in Part C and those that have a higher population of children without insurance or with private insurance that reimburses at a rate lower than Medicaid's. These differences impact the amount of Part C funding each local system needs. For the current year, SFY 2011, local systems are receiving only 75 percent of their allocations. DBHDS plans to review local expenditures and data so that allocations to local programs can be adjusted in the fourth quarter of the fiscal year, April through June, 2011.

Family Cost Share: Consistent with state and federal law, families may be required to contribute to the cost of some Part C services such as specific therapies or equipment. This was formerly called the “Ability to Pay” system but has been renamed Family Cost Share. Services that are provided at no cost to the family include Child Find activities, eligibility evaluation, assessments to identify needed services and supports, service coordination (case management), the development, review, and evaluation of the Individualized Family Services Plan (IFSP), and all activities related to child and family rights and procedural safeguards.

Family contributions are made on the basis of a sliding fee scale with a monthly maximum amount for which the family is financially responsible. This monthly cap is the same regardless of how many agencies provide services or whether more than one child in the family is receiving services. Families cannot be denied services if they are unable to pay towards their cost; however, they must be willing to provide financial information to the Part C system if they wish to participate in the sliding scale. Otherwise, they are held responsible for the full charges of the services received. Financial cost determinations can be appealed or reevaluated if the family’s financial situation changes, and there is an annual reevaluation of a family’s cost share.

Private Health Insurance: In July 1997, coverage of early intervention services up to an annual limit of \$5,000 per insured child became a required part of the Commonwealth of Virginia’s employee health insurance program (*Code of Virginia 2.2-2818*). In July 1998, that mandate was extended to Virginia-regulated accident and sickness insurance policies provided by private companies operating in the state (*Code of Virginia 38.2-3418.5*). Self-insured companies were exempted from this requirement, but some have elected to include this benefit.

The reported proportion of Part C system revenues from private insurers has changed significantly in recent years. The 2004 *Virginia Cost Study* estimated Part C revenues from private insurers to be 12.08 percent of the total, a proportion that remained stable through SFY 2006. In SFY 2007, the percentage dropped to 2.7, followed by 3.2 in SFY 2008 and 2.8 in SFY 2009. It then rose to 6.2 percent in SFY 2010. According to the Part C program, the increase for SFY 2010 was most likely due to a combination of factors related to the Part C Systems Transformation. As indicated on the revenue sources table above, local lead agencies no longer had the option to report an aggregated revenue amount in SFY 2010, and reporting was required of private providers. As a further part of Systems Transformation, DBHDS notes in the 2009 *Report on Virginia’s Part C Early Intervention System* (Budget Item 316 K.2, 2009 *Appropriations Act*) that, in SFY 2011, it will work with the Bureau of Insurance to have private insurance companies implement standard rates for Part C services.

As noted in this chapter’s Introduction, private insurance for children with autism has been a significant issue for more than ten years. The Virginia legislature has considered numerous bills to mandate coverage of certain services including, but not limited to, applied behavioral analysis, an evidence-based practice of intensive intervention advocated by many practitioners in the field. Although strongly supported by parents, many advocates, and professionals, none of these previous bills passed the General Assembly due in part to concerns expressed by the insurance industry about potential increases in the cost of insurance for

businesses and consumers. The Joint Legislative Audit and Review Commission (JLARC) was directed to look into that and other concerns, and in its response to JLARC's 2009 *Assessment of Services for Virginians with Autism Spectrum Disorders*, DBHDS recommended further examination of the autism insurance issue. In 2011, the General Assembly passed House Bill 2467 which provides for mandated private insurance coverage for the diagnosis of an autism spectrum disorder (ASD) and treatment of ASD for children between the ages of two and six. The bill sets a maximum benefit of \$35,000 for applied behavioral analysis and includes other specific parameters, limitations, and exclusions on the mandated coverage. The Governor proposed a number of amendments to the bill after its passage, several of which the General Assembly approved during its reconvened session. The amendments include a requirement for state certification of applied behavioral analysis (ABA) providers, preauthorization of treatment, and an independent review of individual treatment plans.

F. Monitoring and Evaluation of Early Intervention Services

Previous sections of this chapter have already mentioned a number of recent efforts to improve services for infants and toddlers requiring early intervention services. This section will focus on formal monitoring and evaluation mechanism, as well as the on-going efforts to improve the system's data collection and reporting processes.

Early Head Start: Monitoring and evaluation of Virginia's Head Start programs are covered in the Education chapter of this assessment.

Part C Early Intervention: Each state receiving federal financial assistance under Part C of the *Individuals with Disabilities Education Improvement Act* (IDEA) is required to establish an advisory interagency coordinating council to support the lead agency and other agencies providing and paying for Part C services. The **Virginia Interagency Coordinating Council (VICC)** fulfills this requirement by providing guidance on the implementation and evaluation of the statewide early intervention system, including the transition of toddlers with disabilities to preschool and other appropriate services. VICC's membership includes parents, public or private providers of early intervention services, state agency representatives, a legislator, and an individual involved in the preparation of personnel engaged in early intervention services.

Forty **Local Interagency Coordinating Councils (LICCs)** provide advice and assistance to their respective local lead agencies and help to identify existing early intervention services and resources, identify gaps in the service delivery system, and develop local strategies to address those gaps. LICCs also assist their local lead agency in facilitating interagency agreements, support development of service coalitions, and establish local policies and procedures in accordance with federal and state laws and regulations.

Virginia law requires the **Department of Behavioral Health and Developmental Services (DBHDS)** to monitor all state and local public and private agencies and providers of early intervention services, regardless of whether those services are funded by IDEA Part C. To

ensure compliance with state and federal laws and regulations, all public and private early intervention service providers must agree to comply with Part C requirements in writing through an interagency agreement, memorandum of understanding, or contract. New federal Part C regulations were expected to be finalized in August 2010 but, as of the time of this assessment, were still in process. The most recent description of Virginia's system of supervision and monitoring, including how data are gathered and verified, can be found in the *Part C State Annual Program Performance Report for FFY 2008*.

As noted in previous sections, DBHDS has made significant improvements to various components of the Part C system over the last several years. Data collection and reporting system improvements have been among the most challenging. Citing the findings of federal oversight authorities described below, both the 2006 and 2008 editions of this assessment discussed past difficulties in determining exactly how much of total Part C funding was derived from federal, state, local, and fee-based services and how those funds were expended.

In 2006, DBHDS completed an analysis of its existing early intervention data system, the **Infant and Toddler Online Tracking System (ITOTS)**, as well as its other data systems and all federal and state reporting requirements. Following this analysis, its 2007 Part C report (Budget Item 312 K.2., 2007 *Appropriations Act*) cited the following challenges to accurate fiscal reporting: (1) no systemic collection of data regarding planned service levels, (2) no systemic cost information captured, (3) no systemic delivered service information, and (4) no central listing of providers.

To address these issues, DBHDS worked with a long-time collaborator, Solutions Consulting Group, LLC, to develop a plan to improve data collection and reporting. Additional revenue and expenditure reporting elements for local lead agencies were to be phased in beginning in February 2007 and to be operational by July 1, 2009. According to a February 2008 discussion paper (www.infantva.org/documents/wkg-itots-DeliveredSvcInfo.pdf), the following were among the outcomes anticipated through the system improvements proposed by the consultants:

- Ability to accurately project costs based on “actual delivered service” information,
- Ability to monitor actual services vs. planned services in an automated manner,
- Availability of data on staff shortages, cancellation rates, no shows, enrollment, and types of services being provided,
- Existence of an automated mechanism to ensure that subcontractor billing is accurate and billed services have been delivered,
- Ability to provide accurate and comprehensive information as well as cost projections to support funding requests,
- Ability to assess volume of services and funding sources to ensure equitable distribution of funding between state agency and the local lead agencies,

- Automatic computation of Office of Special Education Programs (OSEP) indicator regarding start for time of services (which when done at all, was done manually and was very time consuming), and
- Ability to determine whether the services provided achieved the anticipated or desired outcome.

Full implementation of these improvements was postponed until SFY 2011. The October 2009 Part C report (Budget Item 316 K.2., 2009 *Appropriations Act*) lists the following reasons for the delay:

- As a result of state General Fund reductions for SFY 2009, many local lead agencies were faced with cuts in state funding for Part C. To minimize the impact of those budget reductions on direct services, DBHDS allotted additional federal Part C funds to local systems, thereby reducing funding available for data system enhancements.
- DBHDS and the Department of Medical Assistance Services (DMAS) entered into a collaborative effort to expand Medicaid reimbursements for Part C services through the new Medicaid Early Intervention Program. Additional changes to ITOTS were required to ensure collection and exchange of data between the two departments. These data enhancements were prioritized in SFY 2009 to ensure adequate funding for early intervention services.

Using federal stimulus (ARRA) funding, DBHDS resumed work in SFY 2010 on data system enhancements, design specifications were completed in SFY 2010, and plans for the new data system await administrative approval. While significant challenges remain and the future of the ITOTS system remains under review, DBHDS' October 2009 and 2010 Part C reports (Budget Items 316 K.2 and 305 H.2, 2009 and 2010 *Appropriations Acts*, respectively) identify the following data system improvements to-date:

- As previously mentioned, the revenue and expenditures reporting form now requires information on the number of children receiving each service in each quarter of the fiscal year.
- A separate revenue and expense reporting form was developed in collaboration with private providers to facilitate collection of accurate quarterly financial data.
- A data exchange agreement initiated between DBHDS and the Department of Medical Assistance Services (DMAS) will enable DMAS to report the exact amount of Medicaid funds used to support Part C services each year.

Improving the quantity and quality of service providers has also been an on-going challenge for the Part C system. In the April 2008 *Virginia Cost Study Update* by Solutions Consulting Group, reimbursement rate structures, service costs, and salaries were extensively examined. Detailed information on the process leading to the update's findings can be found in that report, and its recommendations laid the foundation for recent improvements to salary and

rate structures for Part C providers. As noted in the discussion on public health insurance above, implementation of these recommendations is producing significant positive results.

Office of Special Education Monitoring: The U.S. Department of Education Office of Special Education Programs' (OSEP) most comprehensive recent site visit to Virginia's Part C services system was conducted in 2005. That review focused on the data system, monitoring and supervision, and the complaint process. OSEP sought to determine if information collected and reported by the state is reliable, credible, and accurate, as well as to what extent it is used to make policy decisions and ensure compliance with federal regulations. Findings from this visit were reported in detail in the 2006 and 2008 editions of this assessment, as noted above, and will not be repeated here. In brief, many of the deficiencies cited by OSEP related to inadequate data collection and tracking systems, leading to an inability to ensure that data were accurate and could be verified. Significant progress, described above, has been made in this area, but there is still much work to be done.

Additional areas cited by OSEP in 2005, were the need to ensure timely compliance with corrective action plans and establishment of effective sanctions. Progress in all of these areas was noted by DBHDS in its February 2007 *Part C State Performance Plan Update* to OSEP and also covered in the 2008 edition of this assessment.

OSEP conducted its last verification visit to Virginia's Part C services system in 2009 and issued a response to the Commonwealth's submission of its FFY 2008 *Annual Program Performance Report* and revised *State Performance Plan* in June 2010. In its response letter, OSEP found that Virginia met the requirements of Part C of the *Individuals with Disabilities Education Improvement Act (IDEA)* and noted high levels of compliance in a variety of indicators, including some previously found to be noncompliant. Indicators OSEP commended were:

- Percent of infants and toddlers who receive the early intervention services in their Individualized Family Services Plans (IFSP) in a timely manner (94%, up from 89% in FFY 2007; target: 100%).
- Percent of infants and toddlers with IFSPs who primarily receive early intervention services in the home or in community based settings (97%; target: 98%).
- Percent of families participating in Part C who report that these services helped the family:
 - Know their rights (70.8%, up from 66.1% in FFY 2007; target: 66.9%).
 - Effectively communicate their children's needs (67.3%, up from 62.3% in FFY 2007; target: 62.7%).
 - Help their children develop and learn (80.6%, up from 77.5% in FFY 2007; target: 78%).

- Percent of infants and toddlers with IFSPs who demonstrate improved:
 - Positive social-emotional skills (including social relationships).
 - Acquisition and use of knowledge and skills (including early language/communication).
 - Use of appropriate behaviors to meet their needs.

The last indicator listed is new and uses baseline data submitted for federal fiscal year (FFY) 2008 and accepted by OSEP. Its specifics are discussed later in this section.

OSEP noted the need to improve performance on the following indicators reported for FFY 2008:

- Percent of infants and toddlers birth to age one with IFSPs compared to national data (0.67%, down from 0.70% in FFY 2007).
- Percent of infants and toddlers birth to three with IFSPs compared to national data (1.99%, up from 1.92% in FFY2007; target: 2.1%).
- Percent of eligible infants and toddlers with IFPS for whom an evaluation and initial IFSP meeting were conducted within the required 45 day timeline (98%, unchanged from FFY 2007; OSEP required target: 100%).
- Percent of children exiting Part C who receive timely transition planning to preschool or other appropriate services by their third birthday:
 - IFSPs with transition steps and services (98%, down from 99% in FFY 2007; OSEP required target: 100%).
 - Notification to LEA if child is potentially eligible for Part B (99.7%, down from 100% in FFY 2007; OSEP required target: 100%).
 - Transition conference if child is potentially eligible for Part B (96% unchanged from FFY 2007; OSEP required target: 100%).
- General supervision system including monitoring complaints, hearings, etc. and identification and correction of noncompliance as soon as possible but no later than one year from problem identification (98%, improved from 77% in FFY 2007; OSEP required target: 100%).

More recent data from the minutes of the March 2010 Virginia Interagency Coordinating Council (VICC) show that the proportion of infants and toddlers birth to age one with IFSPs has declined further to 0.59 percent, and the proportion of infants and toddlers birth to age three with IFSPs has further increased to 2.03 percent. Neither, however, meets their targets. Further discussion related to this can be found in the Child Find section below.

Virginia's Part C system failed to meet the general supervision indicator above for three years in a row, FFY 2005 through FFY 2007, and was an area that had been found to be in need of assistance. Further discussion of this can be found in the next section on Dispute Resolution.

For these and the other areas cited for noncompliance, DBHDS has initiated a number of corrective activities. These activities are numerous and can be found in the *2005-2010 State Performance Plan's* February 2010 update at www.infantva.org.

Dispute Resolution: Unlike Part B of the *Individuals with Disabilities Education Improvement Act* (IDEA) that covers the special education system, formal complaints in the Part C early intervention system are rare. The *State Performance Plan/Annual Performance Report Response Table* included in the Office of Special Education Programs (OSEP) June 2010 verification letter to the Department of Behavioral Health and Developmental Services (DBHDS) reports that no due process hearing requests were received in federal fiscal year (FFY) 2008. In addition, fewer than ten mediations were held during that fiscal year, and the state is not required to provide targets or improvement activities until a fiscal year in which ten or more such sessions are held.

As noted in the OSEP monitoring section above, only 70.8 percent of families in FFY 2008 indicated that they knew their rights. While this was an increase from 66.1 percent in FFY 2007, it is possible that there is little use of dispute resolution mechanisms in the Part C system because a fair number of families are unaware of or do not know how to exercise their rights with respect to this system.

The 2008 edition of this assessment described plans by DBHDS to develop a dispute resolution handbook; however, the February 2010 amendment to the *2005-2010 State Performance Plan* reported that other means are being used to provide information about resolving disputes and that this activity was discontinued. Activities listed in the amended plan to improve performance with respect to dispute resolution procedures and timelines are:

- Development and implementation of a mechanism to collect data on the number of potential complaints resolved informally through the Part C Office or the Family Improvement Project to determine if there are trends to the concerns expressed by families and to document whether families were informed of their options prior to resolution. This includes a 2011 plan to explore tracking options used in other states and determine the best electronic tracking option for Virginia.
- Reviewing, with staff of the Family Involvement Project and the Virginia Interagency Coordinating Council (VICC), the results of the Parent Education Advocacy Training Center (PEATC) parent survey conducted prior to the 2009 verification visit to assess why the concerns expressed by respondents did not lead to complaints and, if necessary, to develop additional strategies to ensure parents are aware of and empowered to use their dispute resolution options.

Child Find/Children Served: Activities to identify infants and toddlers in need of early intervention services, known as Child Find, have been targeted as an area of focus for monitoring

and improvement for quite a few years. The 2006 and 2008 editions of this assessment noted the fairly significant number of local systems that were required to develop corrective action plans for this performance indicator. Since the 2008 assessment, which described improvement activities at that time, additional efforts have been undertaken, particularly towards serving a greater percentage of the birth to age one population. These are described in the Annual State Performance Plan for 2005-2010, updated in February 2010, and include, but are not limited to:

- Working with the Virginia Department of Health (VDH) and the Virginia Department of Education (VDOE) to develop the statewide VISITS database system that will link to the DBHDS Infant and Toddler Online Tracking System (ITOTS) and use unique child identifiers to automatically refer all children with hearing loss or congenital anomalies to the Part C service system.
- Working with VDH to determine the feasibility of studying outcome data on low birth weight and preterm infants who receive Part C services and contacting states with broad eligibility definitions to see how premature birth is included in those definitions. As a part of this effort, data sharing agreements are being developed by VDH, VDOE, and DBHDS to track these outcomes, and as mentioned in the Access and Delivery section of this chapter, a multidisciplinary, multi-agency workgroup has been convened to study the impact of eliminating the current policy of age adjustment for infants born prematurely and make other eligibility changes to ensure that children needing early intervention services are identified accurately and as soon as possible.
- Contacting states with broad eligibility definitions that serve a high percentage of the birth to age one population to determine their effective public awareness practices and Child Find activities.
- Exploring the feasibility of developing interagency agreements between DBHDS and regional children's hospitals to ensure timely referrals to Part C.
- Partnering with the Virginia Children with Special Health Care Needs (CSHCN) and Virginia Early Hearing Detection and Intervention (VEHDI) programs, described in the Health chapter of this assessment, to enhance procedures and practices that will increase the percentage of infants with permanent hearing loss enrolled in Part C by age six months.

Additional efforts have also been undertaken since federal fiscal year (FFY) 2008 to increase the percentage of infants and toddlers from birth to age three with Individualized Family Services Plans (IFSP). The *2005-2010 State Performance Plan* lists:

- Continuing to revise public awareness materials to ensure appropriateness for underserved populations.
- Facilitating the participation of local systems in a special screening project that involves meetings with referring physicians to discuss referral procedures, available services and supports, and communications between physicians and the local Part C system.

- Developing and implementing a mechanism to track and report specific referral sources through ITOTS.
- Revising the state interagency agreement for Part C to clarify responsibilities with respect to Child Find and referral to the Part C system, including the need to collaborate with Early Head Start and Migrant Head Start to ensure that children served through these systems who may be eligible for Part C are referred.
- Revising family financial contribution procedures to ensure that fees are not a barrier to seeking or accepting Part C services, and implementation of new Family Cost Share practices. (See the Cost and Payment section for details of Family Cost Share.)
- Placing referral information on the Infant and Toddler Connection website.
- Providing training to managed care organizations regarding services and supports available through Part C, how to make referrals, and the role of managed care case managers.
- Implementing a service pathway to ensure a consistent framework for intake, screening, eligibility determination, assessment for service planning, and IFSP development.
- Establishing a state level Child Find and public awareness workgroup focused on strategies for increasing the number served.

Planned activities also include (1) convening a focus group of primary referral sources, including physicians and hospitals, to determine what encourages or discourages referrals to Part C, what type of information would be helpful, and how referring entities would like to receive information and (2) expanding and strengthening partnerships at the state and local level to improve coordination and collaboration for Child Find and public awareness activities.

Medicaid Program Reviews: Implementation of the new Medicaid Early Intervention Program has required additional monitoring. Compliance reviews must be conducted to ensure that services are appropriate, obtained from appropriate providers, and medically necessary, a requirement for Medicaid reimbursement. Quality Management Reviews (QMRs) are conducted by the Department of Medical Assistance Services (DMAS). They include the following components detailed in a joint DMAS/DBHDS Training Presentation on Early Intervention Services:

- Continuing review and evaluation of Medicaid funded care and services,
- Providing technical assistance as needed, and
- Determining whether a compliance review may be necessary.

QMRs can take the form of “desk audits” requiring only access to billing and other records or they may include announced or unannounced onsite visits requiring access to records and facilities. Their activities can include, but are not limited to, observation of service delivery, review of monitoring and supervision activities, and interviews with the child, family, or others. Reviewers look at eligibility determinations, medical necessity, delivered vs. planned and billed

services, delivery of services in natural environments, and appeal rights. Review findings are provided to the audited entity along with recommendations, requirements and timelines for corrective actions, and any additional documentation needs.

Family Survey: As part of federally required monitoring procedures, the state lead agency conducts an annual survey to address the Office of Special Education (OSEP) Indicator #4A-C, the percent of families participating in Part C who report that services have helped the family (1) know their rights, (2) effectively communicate their child's needs, and (3) help their children develop and learn. Each year, families who received early intervention services during the month of May are surveyed, and a random sample of those responding to the survey, which reflects the race/ethnicity of the total population served, is selected for analysis.

In 2008, surveys were returned by 1,883 families, and 1,280 of those responses were selected for analysis. The percentage who responded favorably to each question, the target percentages, and comparable data for 2007 were reported earlier in this section under OSEP Monitoring. For 2009, responses were received from 1,957 families, of which 1,201 were analyzed. The amounts by which favorable responses exceeded their targets showed a small increase from 2008 to 2009 of four percentage points for #4A, knowing their rights; five percentage points for #4B, effectively communicating their child's needs; and two percentage points for #4C, helping their child develop and learn. For families receiving Part C services, this denotes a small increase in positive outcomes in these three areas.

Target percentages remained unchanged from 2009 for 2010, when 1,911 families returned surveys and 1,188 were used to compute the OSEP Indicators. Favorable responses again slightly exceeded their targets by two percentage points for #4A, three percentage points for #4B, and a half percentage point for #4C. Complete information, including methodological considerations, is provided in each year's *Analysis of the Family Survey Data Addressing Part C SPP/APR Indicator #4: Final Report* at www.infantva.org/sup-FamilySurvey.htm.

System for Determination of Child Progress: Effective March 2006, Virginia implemented the federally required System for Determination of Child Progress. All children new to early intervention services with an Individualized Family Services Plan (IFSP), beginning on or after March 1, 2007, are included in the system. The child's IFSP team rates the child's status on three indicators using a seven-point scale upon entry into the system and again upon exit. The three indicators are:

- Positive social emotional skills (including positive social relationships),
- Acquisition and use of knowledge and skills (including early language and communication), and
- Use of appropriate behaviors to meet needs.

Aggregated progress data for all children who exit the system during the reporting timeframe are reported annually to the Office of Special Education Programs (OSEP) in the *Part*

C State Annual Performance Report. For each indicator, the report notes the percentage of the total number of enrolled infants and toddlers who:

- Did not improve functioning,
- Improved functioning but not sufficient to move nearer to functioning comparable to same-age peers,
- Improved functioning to a level nearer to same-age peers but did not reach it,
- Improved functioning to reach a level comparable to same-age peers, or
- Maintained functioning at a level comparable to same-age peers.

The 2008 edition of this assessment reported that performance would be measured against data collected during state fiscal year (SFY) 2008 (July 1, 2007 through June 30, 2008); however, baseline data was gathered instead for children who exited the system during SFY 2009 (July 1, 2008 through June 30, 2009) for whom there was both entry and exit data and who had participated in the Part C system for at least six months. That baseline data can be found in the *Part C State Performance Plan for 2005-2010* as amended in February 2010 at www.infantva.org/documents/ovw-OSEP-PartC-SPP-2007amend2010Feb.pdf. Comparison data are not yet available.

Efforts to improve the Part C early intervention system continue. Ongoing technical assistance is being provided to local systems managers, including a series of five online training modules, available on the Infant and Toddler Connection website, that were developed to ensure consistent training of new providers and existing providers who are new to the system. In addition, a resource manual, *Determining the Status of Infant and Toddler Development in Relation to the Three OSEP Outcomes*, was developed. The Department of Behavioral Health and Developmental Services (DBHDS) notes in the February 2010 amendment to the Part C State Performance Plan for 2005-2010 that this information will be used not only to assess child outcomes, but also to guide service delivery as well as local and state system improvements.

G. Early Intervention Services Sources Referenced in This Chapter

Links to websites and online documents reflect their Internet addresses in March 2011. Some documents retrieved and utilized do not have a date of publication.

Websites:

Head Start

<http://eclkc.ohs.acf.hhs.gov/hslc/About%20Head%20Start>

<http://eclkc.ohs.acf.hhs.gov/hslc/Head%20Start%20Program/Head%20Start%20Program%20Factsheets>

<http://eclkc.ohs.acf.hhs.gov/hslc/tta-system/ehsnrc/Early%20Head%20Start>

Virginia Department of Behavioral Health and Developmental Services:

www.dbhds.virginia.gov

Infant and Toddler Connection of Virginia

www.infantva.org

www.infantva.org/ovw-DeterminationChildProgress.htm

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www.infantva.org/pr-PartCUpdates.htm

www.infantva.org/SupervisionMonitoring.htm

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Virginia Department of Medical Assistance Services

www.dmas.virginia.gov

Virginia Department of Social Services

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III. Education

A. Introduction

All children in the United States are entitled to a publicly funded education. Students with disabilities are also entitled to services and supports, referred to as “special education,” which assure that the education they receive is appropriate to their individual needs.

While public education in the United States is fundamentally a responsibility of state and local governments, the federal government has played a key role in establishing requirements that ensure the education of students with disabilities, starting with the passage in 1974 of the *Education of All Handicapped Act*, (PL 94-142). That statutory milestone has been amended several times and is now known as the *Individuals with Disabilities Education Improvement Act* of 2004 (IDEA, PL 108-446). IDEA established the current nationally mandated requirements for a “**free appropriate public education**” (FAPE) for students with disabilities.

The Virginia Department of Education (VDOE) states on its early childhood website that “**the earlier services are provided for children with disabilities, the better the long-term prognosis. Children with special needs who have experienced support early in life do better in future settings.**” Research shows that participation in programs with typically developing peers is beneficial to all and enhances the language, social skills, and participation in a typical curriculum.” The previous chapter of this report addressed the developmental and early learning needs of infants and toddlers from birth to age three. Under federal law, the transition of children with disabilities from the early intervention services system, Part C of IDEA, to the public education system begins at age three. Virginia, however, has adopted the option of making the transition to preschool special education services, Part B of IDEA, for eligible children as early as age two.

The Virginia Constitution sets forth the state’s responsibility for the education of all students in Article VII, Section 1, and the *Code of Virginia* delineates the specific responsibility for the education of students with disabilities in Sections 22.1-7 and 22.1-213-215. The *Regulations Governing Special Education Programs for Children with Disabilities in Virginia* (8 VAC 20-81-10 *et seq.*) establish the **Virginia Board of Education** requirements regarding special education and related services for children with disabilities. These regulations are applicable to all local school divisions, state-operated programs, the Virginia School for the Deaf and the Blind at Staunton, and private schools in the Commonwealth that provide special education and related services for children with disabilities.

The most recent state regulations became effective in July 2009, following revisions to federal regulations in 2006 that implemented changes enacted in the 2004 amendment of IDEA. State regulations were reissued by the Board of Education following technical amendments, effective January 25, 2010.

In accordance with these federal and state mandates, Virginia's special education system must:

- Be provided under public supervision and direction, at public expense, and without charge;
- Be appropriate to the unique needs of each student as well as to the educational services and environments available for other students of similar age and abilities;
- Include preschool, elementary, middle, and secondary school education;
- Prepare students for further education, employment, and independent living;
- Meet the requirements set by the Virginia Board of Education;
- Be provided in accordance with an Individualized Education Program (IEP);
- Ensure that the rights of children with disabilities and their parents are protected;
- Ensure that parents and educators have the necessary skills and resources to improve educational results for children with disabilities;
- Assess and ensure the effectiveness of the system's efforts to educate children with disabilities; and
- Measure student progress and identify when parents are to be notified of that progress.

A key development since the 2008 edition of this assessment, already mentioned above, has been the promulgation of revised state regulations, effective in July 2009 after a two year development process. According to the *Comparison of Virginia Regulations and IDEA 2004*, published by the **Virginia Department of Education (VDOE)** in February 2010, conformation to the revised federal IDEA regulations required creation of 53 new Virginia-specific provisions in the state's 2009-2010 regulatory revisions.

The process for development of revised Virginia regulations included opportunities for extensive public input, and there was significant discussion among stakeholders and between stakeholders and VDOE with respect to how Virginia should proceed. Some constituent groups wanted Virginia to minimize regulation, conform to federal regulations, and eliminate provisions in which Virginia regulations exceeded federal regulations. Other stakeholders urged the Virginia Board of Education to maintain the Commonwealth's historical commitment to protections for students and families beyond those provided in federal regulations.

The resulting regulations were a compromise between those perspectives. Key parental consent provisions were maintained, as was Virginia's earlier age for transition planning, 14 versus the federal requirement of 16. Among their many provisions, which can be found in full at www.doe.virginia.gov/special_ed/regulations/state/regs_speced_disability_va.pdf, the regulations:

- Revised the concept and name of the long-standing "child study teams" to "school-based teams";

- Decreased the age at which a child can have an educational label of developmental delay from nine to six;
- Established specific eligibility criteria beyond federal definitions for autism, deafness, developmental delay, hearing impairment, intellectual disability, other health impairment, speech or language impairment, and visual impairment;
- Altered provisions relating to timelines for determining initial eligibility and for evaluation/reevaluation, expanding the exception to the deadline when additional data are required to cover all disabilities rather than just specific learning disabilities;
- Established a provision ensuring that parents are provided copies of evaluation reports within a reasonable time period;
- Expanded the requirements for determining eligibility for students with learning disabilities to cover all disabilities;
- Established new provisions relating to determination of eligibility based on individual need and created several additional provisions relating to determination of eligibility;
- Established provisions related to children who do not live with their biological parent, emancipated minors, married minors, children with questionable immigration status, children with long-term placements in state-operated programs, and children in foster care;
- Prohibited local education agencies (LEAs) from restricting the extended school year (ESY) services to summer;
- Clarified that the 30 day timeline which applies to the development of an Individualized Education Program (IEP) following initial eligibility also applies to IEP development following reevaluation and eligibility if changes are needed;
- Created provisions regarding an LEA's determination of the school personnel who will serve on an IEP team, ensuring parental participation, providing IEP copies to parents, documenting whether a child's IEP should include short-term objectives or benchmarks, and expanding notification requirements for transfer of rights to the student at age 18 to provide parents with notice as well;
- Modified certain provisions covering procedural safeguards, including parental notice requirements, Internet posting of safeguards, and consent requirements related to children who are wards of the state;
- Revised the timeframe for appealing due process decisions in state circuit court to 180 days, consistent with *Code of Virginia*, Section 22.1-214B;
- Addressed provision of records and IEP development information for students who transfer from another school division or state; and
- Added a requirement that the membership of local special education advisory councils include a teacher.

Some students with disabilities receive reasonable accommodations to their educational program under **Section 504** of the federal *Rehabilitation Act* of 1973 (29 USC 794), as amended, and its implementing regulations (34 CFR 104). Section 504 states that “no qualified individual with a disability in the United States shall be excluded from, denied the benefits of, or be subjected to discrimination under any program or activity that either receives Federal financial assistance or is conducted by any Executive agency or the United States Postal Service.” This includes local school divisions because they receive federal funds.

Students with disabilities receiving accommodations under Section 504 must have a “504 plan.” This plan is generally developed by a committee consisting of the student with the disability, if appropriate; one or more of the student’s parents or guardians, one or more of the student’s teachers, and the school’s 504 coordinator. A 504 plan, which must be updated annually, documents the student’s disability, his or her need for accommodations, and the set of specific accommodations that will be provided by the school. Later sections of this chapter provide additional details regarding 504 plans and the Individualized Education Programs (IEP) required under IDEA and referenced briefly above.

Laws and regulations governing education services for students with disabilities are extremely complex and cannot be fully covered within the scope of this chapter. This chapter focuses on the major publicly funded special education services that individuals with disabilities may be eligible to receive under IDEA Part B from preschool through high school. These services are provided by **Head Start** programs, public school divisions (formally known as **local education agencies, LEAs**), the **Virginia Department for the Blind and Vision Impaired (DBVI)**, and the **Virginia School for the Deaf and the Blind at Staunton (VDSB-Staunton)**.

VDSB-Staunton was established as a state agency, independent of the Virginia Department of Education (VDOE) by an act of the 2009 General Assembly (*Code of Virginia* 22.1-346), effective on July 1 of that year. Under that act, it has its own Board of Visitors, and the Superintendent of Public Instruction is required to designate a VDOE staff member to serve as a consultant to it on matters pertaining to instruction, federal and state special education requirements, and school accreditation.

Earlier editions of this assessment covered services provided at the Virginia School for the Deaf, Blind, and Multi-Disabled in Hampton. As a result of many legislative and other studies, which considered the dwindling number of students being served and the significantly increasing cost per student, the Hampton school was closed and services were consolidated at the Staunton campus. The 2008 edition of this assessment noted the state’s intention to transform the Hampton campus into a regional day program; however, since then, plans have changed. In a presentation before the House Appropriations Committee in June 2008, *Consolidation of the Two Virginia Schools for the Deaf and Blind*, the Superintendent of Public Instruction reported that, although proposals were solicited over a period of months from entities interested in operating a regional day program, no viable proposals were received.

There are also Virginia children with disabilities who receive special education services in other settings, such as detention centers, local and regional jails, programs operated by the Department of Correctional Education, hospitals, mental health facilities and state-operated training centers, or other residential programs. Detailed discussions of the services provided in those setting is beyond the scope of this assessment.

B. Eligibility for Education Services

Eligible children with disabilities may receive preschool special education services through the public education system, which includes the state-operated program at the Virginia School for the Deaf and the Blind at Staunton (VSDB-Staunton), and through Head Start. Some four-year-olds with developmental delays may also be served under the Virginia Preschool Initiative.

Head Start: Children from birth to age five whose families meet income eligibility requirements receive services promoting academic, social, and emotional development through federally funded and locally operated Head Start programs. Federal Head Start Regulations (45 CFR 1305.4) set forth the following specific criteria for participation:

- A child must be at least three years old by the date used to determine eligibility for public school in the community in which the Head Start program is located, except in cases where the Head Start program's approved grant provides specific authority to serve younger children. Examples of exceptions include programs serving children of migrant families and Early Head Start programs.
- At least 90 percent of the children who are enrolled in each Head Start program must be from low-income families.
- Subject to regulation, up to ten percent of enrolled children can be from families that exceed the low-income guidelines, provided that those children (1) meet the selection criteria that the local program has established and (2) would benefit from Head Start services.
- The *Head Start Act* of 2007 requires that beginning on October 1, 2008, the start of federal fiscal year (FFY) 2008, "not less than ten percent of the total number of children actually enrolled by each Head Start and delegate agency be children with disabilities who are determined to be eligible for special education and related services, or early intervention services ... by the state or local agency providing services under Section 619 or Part C of the *Individuals with Disabilities Education Act* (IDEA, 20 USC 1419, 1431 *et seq.*)."

Since funding may not be available for every child who meets these basic eligibility criteria, each Head Start program is required to have a formal process for establishing its own additional criteria for selecting children to participate. These criteria must ensure that all eligible children are considered and, among other requirements, must consider the availability, or lack

thereof, of kindergarten or first grade for the child. Programs that serve migrant worker populations are required to give priority to those children whose families have had to relocate frequently within the previous two years in order to obtain work.

Federal regulations further require that Head Start grantees, or the agencies to which the grantee delegates the operations of the Head Start program in their area, conduct outreach activities that include strategies to actively locate and recruit children with disabilities. They must also ensure that recruitment staff are knowledgeable of the nondiscrimination tenets of the *Americans with Disabilities Act* (42 USC 12101) and regulations associated with Section 504 of the *Rehabilitation Act* (45 CFR 84). Accordingly, a Head Start program cannot deny placement on the basis of a disability or its severity when (1) the parents wish to enroll the child, (2) the child meets Head Start age and income eligibility criteria, (3) Head Start is an appropriate placement according to the child's Individualized Education Program (IEP), and (4) the program has space to enroll more children, even though the program has made ten percent of its enrollment opportunities available to children with disabilities. In the latter case, children with and without disabilities would compete for available enrollment opportunities.

At the beginning of every program year, each Head Start program is required to develop a waiting list of unselected eligible children which must be maintained throughout that year. Applicants placed on that waiting list must be ranked according to the program's selection criteria to ensure that the most needy children are served first as vacancies occur.

Virginia Preschool Initiative: Children who are not being served by Head Start may be eligible to enter a Virginia Preschool Initiative program, which lists developmental delay as one of the "at risk" categories in its eligibility criteria.

Part B Preschool Services: In Virginia, preschool services are available to eligible children with disabilities from ages two to five. Part B of the *Individuals with Disabilities Education Improvement Act* (IDEA) mandates that such services be available starting at age three, but Virginia parents have the option of either IDEA Part B preschool or IDEA Part C early intervention services for their child between the ages of 24 and 36 months. A separate eligibility determination is required for Part B services from that required for Part C, and children already receiving early intervention services may or may not qualify for special education services following receipt of Part C services. In the best case scenario, successes achieved under the early intervention system may eliminate the need for special education and related services.

K-12 Special Education: Virginia children, adolescents, and young adults with disabilities who have not yet reached their 22nd birthday may be eligible to receive special education and related services provided by local education agencies (LEAs) overseen by the Virginia Department of Education (VDOE). Eligibility for IDEA Part B services at all levels (preschool, elementary, and secondary) involves a standard process. VDOE's *Parent's Guide to Special Education* (www.doe.virginia.gov/special_ed/parents/parents_guide.pdf) was revised in 2010 and provides a clear, user-friendly, and comprehensive guide to the special education process.

Statewide outreach activities by LEAs, known as **Child Find**, are the first step in determining eligibility for Part B services, including early childhood preschool services. Through Child Find, Virginia LEAs must identify, locate, and evaluate children with disabilities who need special education and related services. These children must be identified regardless of citizenship or immigration status, and Child Find must include children who are enrolled in public (including charter) and private (secular or religious) elementary and secondary schools; who are highly mobile, such as children of migrant worker or homeless families; who are under age 18 and incarcerated in a regional or local jail for ten or more days or under house arrest; who are receiving homebound or home-based instruction; and who are receiving services in a private residential placement by a *Comprehensive Services Act* (CSA) team. (The Community Supports chapter of this assessment contains more information on the CSA.) Specific Child Find activities range from broad-based public awareness campaigns to individual screenings that evaluate whether children need specialized educational services.

In addition to Child Find, school professionals may ask at any time for a child to be evaluated to determine if he or she has a disability that would require specialized education. Parents may also contact their child's teacher or other school professional to request evaluations.

"School-based teams" are responsible for making referrals for evaluation. These teams are more flexible than their predecessors, "child study teams," and are designed to be focused on general education with a goal, at least in part, of avoiding unnecessary referrals to special education. The change from child study teams to school-based teams was one of the more controversial revisions to state regulations. Initial drafts of the regulations completely eliminated the child study teams concept.

When a child is referred, either through Child Find or another mechanism, the school-based team reviews the child's education records and other information and makes recommendations regarding the child's educational and behavioral needs. This may include documentation of evidence-based interventions that have been used with the child. A child cannot be found eligible for special education and related services if the reason the child meets criteria is because he or she did not have appropriate instruction in math or reading or uses a language other than English.

School-based teams include the individual who referred the child (unless there are confidentiality issues), the school principal or designee, at least one specialist and one person knowledgeable of alternate interventions and services, and others that are determined necessary. The team can make a referral for evaluation for special education and related services at any time, including during the time frame in which alternate interventions are being tried with the student.

Evaluations for special education and related services require written parental consent. Current state regulations require that evaluations must be completed within 65 business days after consent is given, with exceptions for when a parent refuses to make the child available for

evaluations or when a child transfers to a new school division mid-evaluation. An evaluation for eligibility to receive special education services must address all areas related to the child's suspected disability. Evaluations are multi-disciplinary and typically involve more than one professional. The process may involve assessments by all or some of the following: an educational diagnostician, a school psychologist, occupational and physical therapists, a speech/language pathologist, and a social worker. Based on the results of the evaluation, a team determines whether the child has a disability and whether he or she requires special education and related services as a result of that disability.

To qualify for special education and related services, a child must fall within one of the disability categories specified by the *Individuals with Disabilities Education Improvement Act* (IDEA): autism, deafblindness, deafness, emotional disability, hard of hearing, learning disability, mental retardation (intellectual disability), orthopedic impairment, other health impairment, speech/language impairment, traumatic brain injury, visual impairment, or multiple disabilities. As noted above, the child must also meet the expanded definitions within the newly revised *State Regulations Governing Special Education Programs for Children with Disabilities*. A child can be determined eligible for special education services under the label of "developmental delay" if a school division chooses to use that educational category, but only through age six under the new regulations.

Once determined eligible, reevaluation of the child must occur at least every three years to determine if the child continues to be eligible for special education services. Reevaluations may not occur more than once a year unless the parent and LEA agree otherwise. Reevaluations can be based on existing data, or if these data are insufficient, new data can be gathered.

If a child's parents disagree with the results of the initial or any subsequent eligibility evaluation, they have the right to request an **Independent Educational Evaluation (IEE)** at the school's expense. Parents also have the right to appeal the determination of eligibility and any other decisions that affect their child's education. LEAs have the right to contest the need for an IEE and any other parental appeals. A family can, at all times, obtain an outside evaluation at their own expense if they choose to do so. Any such evaluations must be considered by the school division.

Basic eligibility criteria do not differ for children who may receive preschool or K-12 special education services through the program operated by **Virginia School for the Deaf and the Blind at Staunton (VSDB-Staunton)**. There are, however, additional program admission criteria which are independent of those for determining if a child is eligible for services by a local school district. A student's IEP team makes the decision, based on his or her individual needs, whether services should be received at VSDB-Staunton, and that decision is reassessed annually.

C. Access to and Delivery of Education Services

Both preschool and elementary through secondary (K-12) school services are delivered through local educational agencies (LEAs) and the state-operated programs at the Virginia School for the Deaf and the Blind at Staunton (VSDB-Staunton). LEAs must provide a full continuum of services from least-restrictive placement (the regular education classroom) to the most restrictive placement (homebound or hospital-based instruction). The programs operated at VSDB-Staunton are delivered in a separate school and are considered part of the continuum of placements for all children. Preschoolers also receive services through local Head Start programs and the Virginia Preschool Initiative.

Head Start: The mission of Head Start is to better prepare at-risk children for school and later achievement. Achieving this “school readiness” involves not only the children, but also their families, the schools, and the entire community. Local programs are operated by community action organizations, single purpose agencies, local governments, and public school divisions.

Since its inception in 1965, Head Start has grown nationally to encompass 2,864 programs, including Early Head Start and Migrant/Seasonal Head Start, that served 1,116,466 children in federal fiscal year (FFY) 2010. During that same year, according to the **Virginia Head Start Office** at the **Virginia Department of Social Services (DSS)**, there were 48 Head Start programs in the Commonwealth, and of these, 46 provided preschool services. Fact sheets published by the Administration for Children and Families show that total Head Start enrollment in Virginia, listed below, has remained stable for the past three federal fiscal years (FFY). Information on the 18 Early Head Start programs that provide services for younger children can be found in the Early Intervention chapter of this assessment.

CUMULATIVE VIRGINIA HEAD START ENROLLMENT

<u>Federal Fiscal Year</u>	<u>Enrollment</u>
2008	15,317
2009	15,673
2010	16,319

Source: Administration for Children and Families: *Head Start Program Fact Sheet*.
[http://eclkc.ohs.acf.hhs.gov/hslc/Head%20Start%20Program/Head%20Start%20Program%20Fact sheets](http://eclkc.ohs.acf.hhs.gov/hslc/Head%20Start%20Program/Head%20Start%20Program%20Fact%20sheets).

As noted above, federal Head Start regulations require programs to be proactive in informing families about the program and encouraging them to apply. This specifically includes coordinating their recruitment activities with other early intervention and special education programs, as well as local health departments and practitioners, to identify children with disabilities. Outreach activities suggested by federal regulations include canvassing the local community, news releases and advertising, and the use of family referrals and referrals from other public and private agencies. Local Head Start programs are required to solicit applications from as many eligible families within their recruitment area as possible and, when necessary, to assist those families in completing the application.

Once a child has been determined eligible for and enrolls in a Head Start program, he or she receives services from the Head Start center staff (and from its affiliated Community Action Agencies, where applicable), local educational agencies (LEAs), and a wide variety of other public and private providers. Reflecting the needs and resources of the communities they serve, Head Start activities may occur in group settings, in the home, or in a combination of the two. Services may be half- or full-day, and may or may not be integrated with child daycare. Community assessments, which are updated annually, are used to determine the appropriate design for each setting. Parental involvement and support are key aspects of all Head Start activities. While there is no fee for Head Start services, parents are expected to volunteer their time and talents to the program.

Each child enrolled in a Head Start program, except those enrolled in a migrant program, must be allowed to remain in Head Start until kindergarten or first grade is available for the child in the child's community. A program can choose not to enroll or reenroll a child, however, if there is a change in family income or if there is a child with a greater need for services.

Head Start staff work closely with a wide variety of community resources to obtain training materials and identify service providers. Instructional programs for children with disabilities must address the child's individual needs, strengths, and developmental potential, as well as family circumstances and resources. Developmental assessments are conducted throughout the year. Disability specialists meet monthly with Head Start teachers and work closely with the local education agency (LEA) service providers to monitor each child's progress and coordinate activities.

The Head Start *Program Information Report* for federal fiscal year (FFY) 2009 reports that 11.9 percent of the children participating in Virginia's Head Start programs had an Individualized Education Program (IEP) in the year prior to their enrollment, compared to 11.5 percent nationally. For FFY 2010, the percentage in Virginia was 12.6 percent, compared to 11.9 percent nationally.

The 2008 edition of this assessment reported a 7.4 percent decline in the number of Virginia Head Start enrollees with a primary disability from 1,928 in FFY 2004 to 1,786 in FFY 2006. As the table below illustrates, this decline continued into FFY 2008, then returned to the FFY 2006 level over the past two years. This trend is mimicked by data for the individual categories with higher numbers, but as might be expected, there is more variability for the categories with lower counts. The number of children diagnosed with autism has not increased significantly despite well-publicized increases in the prevalence of autism spectrum disorders (ASD). While no specific conclusions can be drawn from this data, late diagnosis of ASD is the likely cause. Children who ultimately have a diagnosis of autism may be receiving services in the categories of non-categorical developmental delay or speech impairment. The reason for the spike in the number of children with an emotional/behavioral disability for FFY 2009, an anomaly which has been confirmed by the Virginia Head Start Office, is not known.

**PRIMARY DISABILITIES OF PRESCHOOL CHILDREN
RECEIVING HEAD START SERVICES IN VIRGINIA**

Federal Fiscal Year	2007	2008	2009	2010
Autism	18	22	16	19
Developmental Delay, Non-Categorical	543	491	537	565
Emotional/Behavioral	5	8	116	29
Health Impairment	16	9	14	9
Hearing Impairment	3	2	11	12
Intellectual Disability	1	2	7	3
Learning Disabilities	20	23	18	29
Orthopedic Impairment	7	7	6	2
Speech Impairment	1,015	979	970	1,063
Traumatic Brain Injury	0	2	1	0
Vision Impairment	6	4	5	5
Multiple Disabilities	47	59	27	46
TOTAL	1,681	1,608	1,728	1,782

Source: Virginia Department of Social Services, Virginia Head Start Office.

Virginia Preschool Initiative: Some Virginia localities provide services for at-risk four-year-olds, including those with developmental delay, through this grant-funded program managed by the Virginia Department of Education (VDOE). To obtain state funding, the *Guidelines for the Virginia Preschool Initiative Application* requires localities to develop a written local plan for programs that include five services: quality preschool education, parental involvement, comprehensive child health and social services, and transportation. They are further expected to coordinate resources and funding streams to serve the greatest number of eligible children. Localities receiving funding can use it to:

- Establish or expand quality, comprehensive preschool programs in public schools or community sites,
- Purchase quality preschool education programs and services for at-risk four-year-old children from existing providers,
- Expand existing quality programs to serve more children, and
- Upgrade existing programs to meet criteria for comprehensive, quality preschool programs to serve new, unserved children.

Localities are required to use a tool called the **Phonological Awareness Literacy Screening-PreK (PALS)** during the fall and spring of each school year, and their program's curriculum must align with **Virginia's Foundation Blocks for Early Learning**. The Foundation Blocks establish a measurable range of skills and knowledge essential for four-year-olds to be successful in kindergarten. They provide early childhood educators with a

comprehensive set of standards, indicative of success for entering kindergarten, that are derived from scientifically based research.

Enrollment data for the Virginia Preschool Initiative does not distinguish between the number of children with disabilities and other at-risk children served by the program. For the 2006-2007 school year, the first for which VDOE reported enrollment on the Virginia Performs website, enrollment in the initiative was 11,343. Data below for the past two years shows a significant increase since then, 40 percent by school year 2009-2010, which enabled VDOE to well exceed its enrollment target of 15,000.

CUMULATIVE VIRGINIA HEAD START ENROLLMENT

<u>School Year</u>	<u>Enrollment</u>
2008-2009	15,639
2009-2010	15,901

Source: Virginia Department of Education (VDOE). Retrieved from Virginia Performs: <http://vaperforms.virginia.gov/agencylevel/src/displaymsr.cfm?measureid=20100000.001.001>.

Part B Preschool Services: Early childhood special education services are provided by local school divisions to eligible children who have an Individualized Education Program (IEP). Procedures for accessing Part B preschool services are the same as those for children accessing Part B elementary or secondary school services. Those procedures and enrollment statistics are covered below under K-12 Special Education.

K-12 Special Education: The *Individuals with Disabilities Education Improvement Act* (IDEA) and companion federal and state regulations require that schools receiving federal funds provide eligible students with disabilities with a “free appropriate public education.” Once determined eligible for special education services as described in the section above, an **Individualized Education Program (IEP)** must be developed for the student within 30 calendar days. The IEP is the cornerstone of a high-quality education for each child with a disability. It specifies the special education and related services to be received and identifies the settings in which those services will be delivered. An IEP is similar to the Individualized Family Services Plan (IFSP) previously described for the Part C Early Intervention system, but once past the preschool years, the IEP tends to be less family-centered. An IEP focuses specifically on the educational needs of the student and on the services provided through the education system.

To create an effective IEP, parents, teachers, other school staff members, and the student, when appropriate, come together to look closely at the student’s unique needs and strengths. These individuals pool their knowledge, experience, and commitment to design an educational program that will support the student’s involvement and progress in the general curriculum and ensure equal access to programs and services. By law, the IEP must include information on:

- The student’s current level of achievement and functional performance;

- Measurable annual goals;
- Short-term objectives/benchmarks for students not participating in the Standards of Learning curriculum (note that the IEP team can agree to include short-term objectives in the IEP of a student who is not in an alternate curriculum);
- Special education and related services needed to meet his or her individual needs, necessary supplementary aids, and resources;
- A determination on participation in division-wide and statewide assessments;
- An explanation of the extent, if any, to which the child will not participate with children who do not have disabilities in the regular class and in other activities;
- The frequency, duration, and location of services as well as modifications to them, and transition service needs and transition services at the appropriate age;
- The environment in which special education services will be provided;
- How the child's progress toward the annual goals will be measured and when periodic reports on the child's progress in meeting annual goals will be provided;
- Secondary transition services including postsecondary goals and transition services beginning at age 14 and a statement of interagency responsibilities and linkages beginning at age 16 or younger if appropriate; and
- A statement of rights at age of majority at least one year prior to a student turning 18.

Students who receive services under an IEP are entitled to have those services delivered in the “**least restrictive environment**” (LRE) and must have a “**continuum of placements options**” available to them. This continuum allows for special education and related services to be provided within a general education classroom, a self-contained classroom, a resource room, a private day program, a residential program, a hospital, the home (homebound), or any other approved setting. Within the construct of the continuum of placements, LRE means that students with disabilities: (1) have the right to be educated with their peers who do not have disabilities and (2) cannot be moved to special classes, placed in separate schools, or otherwise removed from the general education environment unless it is demonstrated that, because of the nature and severity of their disabilities, they cannot be educated in a regular education class through the use of supplemental aids and services.

Inclusive practices in which children are served in the regular education classroom are considered “best practice”; however, inclusive practices are not a legal principle. “Placement in the LRE” is the legal requirement, which may or may not result in a child receiving services in a regular education classroom. The decision regarding the environment in which special education services will be delivered must be based on the unique needs of the student and the most appropriate environment in which that student's IEP goals can be met, consistent with the tenets

of LRE. Regardless of the type of setting in which services are delivered, IDEA requires that students with disabilities have access to the general educational curriculum to the maximum extent appropriate. In Virginia, the general curriculum is the **Standards of Learning (SOL)** curriculum. All students must be considered for participation in the SOL assessments with or without accommodation.

Once an IEP has been developed and agreed on, the **local education agency (LEA)** is responsible for ensuring that it is carried out as written. Parents must be given a copy of the IEP, and each of the student's teachers or other service providers must have access to it. Doing so helps to guarantee that everyone involved in educating the student is fully aware of the specific accommodations, modifications, and supports that must be provided in order to carry out the IEP. The student's progress toward achieving the IEP's annual goals must be measured, and parents must be routinely informed of the child's progress. Generally, the student's plan is reviewed by the IEP team at least once a year, but reviews may occur more often if requested and agreed to by both the parents and the school.

Until a student graduates with a standard or advanced studies high school diploma or reaches his or her 22nd birthday, special education and related services cannot be terminated without an evaluation by the school that finds him or her no longer eligible for services. That evaluation can be a review of existing information or the result of new assessments.

At times, parents may not agree with a student's IEP, the location in which services will be delivered, or other issues regarding the provision of services, such as the "free appropriate public education" (FAPE) or LRE requirements. In such cases, they are encouraged to discuss their concerns with other members of the IEP team to work out an agreement. If the disagreement persists, parents may participate in more formal dispute resolution practices including, but not limited to, filing a formal **complaint**, requesting **mediation**, or filing a **due process request**. Participation in mediation is always voluntary. Both parties in the dispute must agree to participate. Under federal law and regulations, school divisions are also required to offer a **resolution** session to parents. Additional detailed information on dispute resolution mechanisms is available from the Virginia Department of Education (VDOE) and described in the monitoring and evaluation section of this chapter.

VDOE annually collects data from LEAs on the number of children receiving services on the same day, December 1. This **December Child Count** is a "point-in-time" census and does not represent the total number of children served during the year. The table below shows the number of children with disabilities receiving special education and related services statewide by disability category for every other year from 2003 through 2009. Over this period, the total number of students reported in the December Child Count declined by 4.6 percent.

STUDENTS RECEIVING SPECIAL EDUCATION SERVICES, DECEMBER CHILD COUNT

VDOE Disability Category	12/1/2003	2005	2007	2009
Autism	3,966	5,674	7,580	10,092
Deafblindness	13	31	13	20
Developmental Delay	13,351	14,945	15,178	13,226
Emotional Disturbance	13,058	12,425	11,011	10,125
Other Health Impairments	21,749	25,600	26,947	27,811
Hearing Impairments	1,563	1,538	1,547	1,489
Intellectual Disability	13,064	11,823	10,409	9,913
Specific Learning Disabilities	70,188	65,686	60,628	57,566
Orthopedic Impairment	851	934	910	912
Speech/Language Impairment	31,337	32,239	30,476	29,771
Traumatic Brain Injury	348	369	393	402
Vision Disability	507	486	541	612
Severe Disability	1,060	970	978	796
Multiple Disabilities	2,816	3,010	2,927	3,139
TOTAL	173,871	175,730	169,538	165,874

Source: Virginia Department of Education: December Child Count for 2003, 2005, 2007 & 2009 for school divisions and state operated programs. Note that, at the time of this assessment, data from the 2010 December Child Count were not yet available.

At the same time, the number of children with an educational classification of autism has continued to increase dramatically, by 150 percent, from 3,966 in 2003 to 10,092 in 2009. In just the past two years, it has increased by 33 percent, from 7,580 in 2007, and a further increase is anticipated when data from the 2010 December Child Count become available. There is likely a combination of reasons for this trend: (1) a real increase in children diagnosed as having an autism spectrum disorder (ASD) and earlier identification of children with ASD; (2) more appropriate educational classification of young children who may have previously had an educational label of intellectual disability, severe disability, emotional disturbance, or developmental delay; and (3) increased vigilance by parents and educators, due in part to widespread national media coverage, that has raised awareness of the characteristics of autism and led to earlier identification.

The **Virginia School for the Deaf and the Blind at Staunton (VSDB-Staunton)** is one of the available educational resources for a student who is deaf, blind, or deafblind, and placement at VSDB-Staunton is determined by his or her IEP team. Drawing on the letters in its acronym, the school's 2010-2012 *Strategic Plan* describes its mission as: "to provide educational programs and services to students ages two through 21 who are deaf, blind, and multi-disabled. Educational and residential services shall promote: V—Value for each person and their unique abilities, S—Success in meeting each student's academic goals, D—Diversity in instruction to meet the needs of all students, B—Building opportunities that foster expertise in technology and its integration, communication, and achievement for all staff and students and their families."

D. Available Education Services

Head Start Preschool: “Funded enrollment” in Head Start refers to children whose participation is federally supported. Total enrollment also includes children whose families contribute toward their participation because the family’s income is too high to qualify for federal support. During the 2010 program year (federal fiscal year, FFY), 61 percent of the funded-enrollment children served by Virginia’s 48 Head Start grantees received full-day, center-based services for five days a week. Another 20 percent received part-day, center-based services for four days a week. Many of the Head Start grantees offer additional services to meet the needs of working families, including full-time day, home-based, a combination of center- and home-based, family child care, and locally designated options.

As noted previously, Head Start focuses on school-readiness and the development and demonstration of skills in literacy, language knowledge, listening comprehension, mathematics, science, creative arts, social and physical development, and approach to learning. Key services provided to children with disabilities and their families can include professional medical, dental, mental health, and other diagnostic screenings and referrals to service providers; nutrition programs; and information and training for parents, staff, and service providers on how to better meet the special needs of participating children.

Students who participate in Head Start who have an Individualized Education Program (IEP) receive all of the services in their IEPs as well as comprehensive Head Start services. Head Start programs are also required to develop plans for the transition of children to public schools, and collaborative agreements exist between Head Start, schools, and other relevant organizations to facilitate that process.

Virginia Preschool Initiative: Programs funded through this initiative provide instruction in math, science, history, and social science, as well as physical and motor development and personal and social development. As described earlier, curricula in these areas prepare at-risk four-year-olds to enter kindergarten and are based on Virginia’s *Foundation Blocks for Early Learning: Comprehensive Standards for Four-Year-Olds*, published in 2007.

Part B Preschool Services: As with the other preschool programs described above, the goal of these services is to ensure that children are as prepared to enter kindergarten as possible. Preschool services focus on development of age-appropriate social/emotional skills, including social relationships, acquisition and use of knowledge and skills such as early language and early literacy, and the use of appropriate behaviors to meet needs. Eligible preschoolers are provided with all of the services and supports deemed necessary in their Individualized Education Programs (IEPs). Available services are the same as for K-12 special education and are listed in that section below.

In addition to locally provided Part B preschool services, the **Virginia School for the Deaf and the Blind at Staunton (VSDB-Staunton)** offers preschool services for children who are deaf, hard of hearing, or who have cochlear implants. Its *Program of Studies for 2010-2011*

describes services for preschoolers that focus on hands-on developmentally appropriate instruction designed to achieve maximum development of language, cognition, social/emotional skills, motor skills, speech, and listening skills. The curriculum is based on the child's interests as revealed through play, conversations, and interactions with their environment. Preschoolers go on regular field trips that help foster overall growth and improved communication. Early literacy development is emphasized and the Creative Curriculum and the state-mandated Building Blocks standards are followed. Preschool students also participate in physical education and art classes. Families are an important part of the preschool program and receive daily communications in a variety of forms, as well as monthly home visits from members of their child's team to share additional information about their child's needs and progress. Parents participate in various activities with their child throughout the school year and are provided workshops to enhance their learning and interaction with their child.

The **VSDB-Staunton Audiology Clinic** is an approved diagnostic testing site for Virginia's Universal Newborn Hearing Screening Program coordinated through the Department of Health (VDH). Evaluations of public school children are done at the request of local school systems to identify children with hearing loss as early as possible so that needed services and supports can be provided.

K-12 Special Education: Services available to students found eligible for special education under Part B of the *Individuals with Disabilities Education Improvement Act* (IDEA) start with specially designed instruction in core academic areas. As noted earlier, services must be delivered in the "least restrictive environment," and a full continuum of placements must be offered. In addition to instruction in core academic areas, a partial list of additional related services that may be required for a student with a disability, regardless of placement, includes:

Counseling, including rehabilitation counseling	Psychological services
Early identification and assessment	School health/nurse services
Medical services (within criteria)	Social work services
Orientation and mobility services	Speech language pathology and audiology services
Physical and occupational therapy	Transportation

Other developmental, corrective, or supportive services may also be provided if required for a child with a disability to benefit from special education. The **Department for the Blind and Vision Impaired (DBVI)** consults with Virginia schools to provide comprehensive programming to students who are blind, vision impaired, or deafblind. Services provided by DBVI include educational and developmental materials, vision assessments and eye exams, and adaptive optical aids. To meet federal requirements for accessible instructional materials needed by students with print disabilities, a center has been established at **George Mason University (GMU)** to process textbooks and other instructional materials into various formats including talking books and Braille and provide them to all local school divisions, as needed and requested.

All students must be included in the state's accountability system and must be first considered for participation in the **Virginia Standards of Learning (SOL) Assessment**. A student's Individualized Education Program (IEP) must specify whether the student is participating in the SOL Assessment, with or without accommodation, or in one of the Commonwealth's alternate assessment programs: the **Virginia Alternate Assessment Program (VAAP)**, the **Virginia Grade Level Alternative (VGLA)**, the **Virginia Modified Achievement Standards Tests (VMASST)**, or the **Virginia Substitute Evaluation Program (VSEP)**. A child must meet the specific criteria for participation in an alternate assessment and their use is intended to be limited. Information about these assessment options and their potential impact on course of study can be found at www.doe.virginia.gov/students_parents/index.shtml#testing.

The 2010 General Assembly passed House Bill 304 to further ensure that students are not inappropriately directed away from the SOL Assessment. Subsequently, in April 2010, the Virginia Department of Education's Superintendent of Instruction (VDOE Superintendent's Memo #096-10) informed local school division superintendents of changes to the VGLA implementing specific criteria for participation by students with disabilities who have an IEP or a 504 Plan beginning with the 2010-2011 school year. IEP teams and 504 committees are required to provide a justification and supporting documentation to explain why they have determined that the student's disability prevents him or her from participating in the SOL Assessments even with accommodations.

Earlier editions of this assessment noted differences between K-12 instruction at the Virginia School for the Deaf and Blind in Staunton and the Virginia School for the Deaf, Blind, and Multi-Disabled in Hampton. With their merger to form the **Virginia School for the Deaf and the Blind at Staunton (VSDB-Staunton)**, changes were implemented to their consolidated curricula which now provides training in student's disability areas as well as concentrated instruction in core academic areas. As is the case with local school divisions, VSDB-Staunton is required to follow all federal and state regulations pertaining to the education of students with disabilities.

VSDB-Staunton's **Department for the Blind** focuses on enabling students to become independent, emphasizing literacy, the development of a primary reading medium, and the use of technology. The instructional program focuses on continuous academic and compensatory skill development for each student and provides opportunities in areas such as, but not limited to, keyboarding proficiency, organizational and study skills, Braille, assistive technology, use of recorded text and voice output, and social interaction and self-advocacy skills. Individual and group instruction is also provided for students in body image, organization, sensory awareness, and independent travel. In addition, a behavioral management specialist conducts individual and group counseling in the areas of emotional, social, and behavioral needs and concerns.

Just as in the public school system, students can take electives in their areas of interest, and they can also enroll in vocational classes at the Valley Vocational Technical School or college courses at Blue Ridge Tech Prep Academy. Additionally, students may be eligible to

take certain classes at local high schools. All students participate in SOL Assessments and can pursue all available diploma options.

Although currently suspended due to ongoing facility renovations, VDSB-Staunton also offers an outreach service, the **Summer Enrichment Program**. This program for students from across the state with vision loss is presented over five days and based on history themes. Four basic courses cover Reading/Study Skills, Math/Money Management, Independent Living Skills, and Everyday Technology/Signature.

VDSB-Staunton's **Department for the Deaf** provides services leading to independence for children with severe to profound hearing impairments. Providing students with the tools to communicate effectively is the program's key function. Both the general education curriculum and the Standards of Learning (SOLs) are covered. Comprehensive academic and vocational offerings are provided as are diagnostic, habilitative, and rehabilitative services in the areas of speech, reading/language, and auditory training. A parent-education teacher works to assist parents in communicating better with their children. As in the Department for the Blind, a behavioral management specialist is available for individual and group counseling to address social, emotional, and behavioral needs and concerns, and students with hearing loss can take courses at Valley Vocational Technical School. Students are given opportunities to take courses in local public schools and to experience work-related activities through jobs acquired in the community. As part of each student's Individualized Education Program (IEP), a transition plan is developed and updated annually, including preparation for the Standards of Learning (SOLs) and other standardized tests.

Part B Transition Services: During adolescence, preparation for postsecondary education, training, or employment is a critical addition to a student's Individualized Education Program (IEP). Federal and state laws and regulations define transition services as those that "promote movement from school to post-school activities, including postsecondary education, vocational training, integrated employment (including supported employment), continuing and adult education, adult services, independent living, or community participation." While the federal minimum age for commencement of transition planning has recently been raised to the year in which a student turns 16, the Virginia Department of Education (VDOE) has continued to encourage that transition begin as early as needed and has maintained age 14 as the minimum transition age in its state special education regulations.

To be most effective, and by law, transition planning must be based on the individual student's needs, taking into account his or her strengths, preferences, and interests. Transition preparation can include direct instruction, community experiences, development of employment and other post-school adult-living objectives, and other related services. When needed, acquisition of daily living skills and a functional vocational evaluation may be included. Whether it is anticipated that a student will receive a Special, Modified Standard, Standard, or Advanced Studies diploma from a Virginia high school or "age out" of the system when IDEA Part B eligibility ends at age 22, school divisions must provide special education students with a summary of academic achievement and functional performance, including recommendations on

the assistance needed to meet postsecondary goals. While some states end eligibility on the student's actual 22nd birthday, students in Virginia are able to continue in secondary school throughout the year in which they turn 22.

VDOE has an excellent website on transition resources and has devoted significant resources to promotion of best practices and provision of technical assistance for transition. It offers all school divisions an opportunity to participate in the Virginia Transition Outcomes Project, sponsors an annual transition conference, and provides 16 regional transition specialists to support local public schools.

Primary responsibility for planning and implementing transition services rests with the local educational agencies (LEAs), but other agencies and organizations may be called on to assist. Contingent on students' individual needs and eligibility for services, examples of this assistance include:

- Case management, job-related, or other services from Community Services Boards (CSBs), behavioral health authorities, or other appropriate providers;
- A Home and Community Based Services (HCBS) Waiver support coordinator;
- Peer-counseling and other support services from Centers for Independent Living (CILs);
- Vocational rehabilitation, including services offered by the Virginia Department of Rehabilitative Services (DRS) and the Department for the Blind and Vision Impaired (DBVI);
- Social Security and work incentives planning programs;
- Exploration of postsecondary employment training opportunities offered by colleges, trade schools, and other providers; and
- Transition services and employment programs, which typically do not have a specific focus on disabilities, available from the Department of Labor.

The interagency **Postsecondary Education/Rehabilitation Transition (PERT)** program, operated by DRS' Woodrow Wilson Rehabilitation Center (WWRC) in Fishersville, is available to all LEAs and many choose to participate. The PERT program's advisory committee, comprised of parents and former participants, focuses on helping students achieve a smooth transition to postsecondary activities. Local PERT teams within each participating school division identify appropriate students to participate in PERT evaluations then work with those students and their IEP teams to plan and implement educational and rehabilitative services based on the results.

There are two components to the PERT program. An initial, five- to ten-day, residential evaluation at WWRC determines students' vocational strengths and aptitudes, independent-living and leisure skills, and functional abilities, as well as their social, interpersonal, and personal-adjustment skills. Findings and recommendations resulting from this evaluation are used by local PERT teams to address the school-to-work transition component of the students' IEPs.

Participation in a Situation Assessment, the second component of PERT, is the result of IEP recommendations made at the local level. Students who undergo this assessment have the opportunity to further refine their vocational interests and skill areas, develop good work habits, and clarify their vocational goals.

In state fiscal year (SFY) 2009, PERT conducted a total of 498 evaluations. Of these, 438 were initial evaluations, 59 were Situation Assessments, and one student was identified as being a “youth in transition.” This is a slight decline from SFY 2007, when 512 assessments, 451 initial evaluations plus 61 Situational Assessments, were performed. Additional information on PERT can be found at www.wvrc.virginia.gov/pertprogram.htm.

Blind and vision impaired students in 10th through 12th grade and adults who are considering resuming their education may be eligible to participate in a two-week assessment program by the **Department for the Blind and Vision Impaired (DBVI)** that determines their readiness for college, both in terms of academic and adjustment-to-blindness skills. DBVI also offers a four-week transition program for blind high school students that includes the opportunity to participate in community work experiences. Students enrolled in this program receive training in independent-living, cooking, personal management, computer, and orientation and mobility activities to develop their skills in these areas. Due to several years of low enrollment, DBVI no longer offers its one-week computer exploration program for 14- to 21-year-olds. Instead, it now offers Saturday afternoon technology classes three to four times per year that build keyboarding and Braille technology skills, computer literacy and competency with various software applications, and expertise with voice, image-enlargement, or Braille access for computer use.

There are some interesting trends with respect to planning for students in transition, and transition services continue to be an area of concern for students and their parents. Despite significant work at the state level within VDOE, services vary considerably across the state, and families continue to cite challenges in receiving adequate information and the supports needed to ensure success after high school for students seeking employment.

Overall, the December Child Count census of students receiving special education services has declined by 5.5 percent from 175,579 in 2004 to 165,874 in 2009, and the number of students with disabilities within Virginia’s “official” range for transition services, ages 14 to 22, has decreased by 3.6 percent for the same period, from 60,718 to 58,505. The number of children ages two to 13 with disabilities “in the pipeline” for future transition services is also trending down. Despite these declines, however, the number of students who require appropriate transition services in order to be successful in employment or postsecondary education remains high, and the number nearest to school exit, those between the ages of 18 and 22, has actually increased by 21 percent according to the December Child Count, from 8,432 in 2004 to 10,219 in 2009.

In contrast to the overall trends above, the number of students with autism spectrum disorders (ASD) who require transition services has increased substantially, and makes planning for these students particularly challenging. Consistent with the growth in prevalence and

identification of this disability, the number of students ages of 14 to 21 identified as having ASD rose from 1,021 in 2004 to 2,690 in 2009, an increase of 163 percent. Those closest to transition, between the ages of 18 and 21, increased by 153 percent over that same period, from 245 to 621. To meet this need, in 2010, VDOE developed a *Transition and ASD Guidance* document to help students, families, and professionals navigate the transition years, develop and implement quality transition plans, and reduce barriers to post-school success. This guide complements VDOE's overall *ASD Guidance*, *Parents Guide*, and *Models of Best Practice* documents which, at the time of this assessment, were in final editing stage and expected to be released prior to the conclusion of the 2010-2011 school year. Their impact on the success of students with ASD, however, will be dependent on practices of the local school divisions serving these students.

E. Cost and Payment for Education Services

Head Start: Federal funding for Head Start is provided through the Head Start Bureau, Administration on Children, Youth, and Families (ACYF), Administration for Children and Families (ACF) of the Department of Health and Human Services (DHHS). Grants are awarded directly to local public agencies, private organizations, Native American tribes, and school systems for the purpose of operating Head Start programs at the community level. Any local public, private nonprofit, or for-profit agency or organization capable of providing a suitable organizational base is eligible to apply for funding to establish a Head Start program within a specified community, such as a single city or county, a multi-jurisdictional unit within a state, or a Native American reservation.

Nationwide, funding for Head Start was approximately \$7.1 billion in federal fiscal year (FFY) 2009 to provide services for participants both with and without disabilities and increased slightly to \$7.2 billion in FFY 2010. From FFY 2004 to 2008 Virginia's federal allocation for Head Start was in the \$98 million to \$99 million range, with the state receiving \$99,358,903 for FFY 2008. Virginia's allocation increased by 3.1 percent to \$102,461,544 in FFY 2009, partly due to an additional allocation of \$2.1 million in federal stimulus (ARRA) funds specifically targeted for Head Start. Information on Virginia's allocation for FFY 2010 was not available at the time of this assessment.

The vast majority of Head Start appropriations are used to fund the services provided by local Head Start programs; however, a portion is used for training and technical assistance to assist those projects in meeting program performance standards and to maintain and improve the quality of local programs. Some funds are also used for research, demonstration, and evaluation activities. Federal rules further require that localities provide matching funds equal to 20 percent of federal funding, which must come from non-federal sources either in cash or in-kind contributions such as facilities, equipment, or volunteer services.

Virginia Preschool Initiative: Virginia Lottery proceeds specifically designated for this initiative are distributed to local schools and community-based programs by the Virginia

Department of Education (VDOE). The 2010-2012 *Appropriations Act* provided \$67,607,769 for the first year of the biennium and \$68,300,290 in the second year.

Funds are granted based on an allocation formula that takes into account the number of at-risk four-year-olds served in each locality for full-days and half-days. The locality receives the full state share of the \$6,000 total grant amount for each child in a full-day, school-year program. Programs that operate half-days receive state funds on a fractional basis determined by the *prorata* portion of a full-day, school-year program. Local matching funds are required based on a composite index of local ability to pay. At least 75 percent of this match must be in cash with in-kind contributions making up no more than 25 percent. Further details on the funding formula can be found in the relevant item of the *Appropriations Act* at www.doe.virginia.gov/instruction/early_childhood/preschool_initiative/appropriation_act_language.pdf.

Preschool through K-12 Special Education: The following chart summarizes the combination of local, state, and federal resources used by local school divisions in Virginia to fund special education services for students with disabilities in state fiscal years (SFY) 2007 and 2009. Total funding for SFY 2009 increased 9.8 percent over funding in SFY 2007 and has risen approximately 26 percent since SFY 2006 when it was \$1,644,878,544.

VIRGINIA SPECIAL EDUCATION FUNDING BY SOURCE AND YEAR

Funding Source	State Fiscal Year		**SFY 2009	
	*SFY 2007	Share	Amount	Share
Localities	\$1,184,672,203	63%	\$1,307,410,243	63%
State appropriations to localities	432,980,961	23%	519,749,897	25%
Federal payments to state, IDEA Part B		14%		12%
Section 619 (Preschool)	9,125,517		6,709,324	
Section 611 (School-age)	259,641,368		238,145,537	
TOTAL	\$1,886,420,049	100%	\$2,072,014,801	100%

*Source: Virginia Department of Education: Financial and Data Service Division, January 2008.

**Source: Virginia Department of Education: Financial and Data Service Division, November 2010.

At the time of this assessment, local and state funding amounts for SFY 2010 were not final. Anticipated federal funding for SFY 2010 appears below. This chart shows both IDEA Part B funding and additional grant awards of federal stimulus (ARRA) funds for the year.

VIRGINIA'S FEDERAL SPECIAL EDUCATION FUNDING FOR SFY 2010 (*Preliminary Data*)

Federal Funding Source	IDEA Part B	Stimulus (ARRA)
Section 619 (Preschool)	\$6,626,201	\$9,476,492
Section 611 (School-age)	\$249,605,515	\$281,415,034

Source: Virginia Department of Education: Financial and Data Service Division, November 2010.

Local funding involves interaction between municipal school boards and governing bodies. The school board projects the cost for local education programs, subtracts the anticipated

receipts from state, federal, and other sources, then submits a budget request to the city or town council or county board of supervisors. These local governing bodies then approve what they believe to be appropriate funding to support their localities' schools. This amount may be more or less than the amount requested by the school board.

State funding to local school divisions are determined by their enrollment using a measure referred to as their **average daily membership** (ADM). The state provides each locality with a base amount of funding for each child counted in its ADM plus per-child "add-ons" for special education and other activities. The special education add-on is determined by calculating the theoretical number of teachers and aides needed to meet special education standards for the number of enrolled children receiving special education and related services counted in the annual December 1st Child Count. The state's share of this cost is determined according to a formula, the locality's composite index of ability to pay.

Under this system, each local school division receives an amount of funding from the state for special education that is unique to that locality. The total amount received for special education is dependent on the total student enrollment of the school division, not on the specific number of students receiving special education services. Further, state payments of the special education add-on are made into the general fund of each local school board where they are commingled with all other state appropriations to localities for education.

Under certain conditions, eligible students may be served in public regional special education programs. Tuition rates charged to school divisions by these locally operated programs are approved by the Virginia Department of Education (VDOE). Students served in these programs are not counted in a locality's ADM and, therefore, are not included in determining a locality's per-child basic or add-on funding from the state. At the end of each semester, school divisions may request reimbursement from the state for its share of this tuition. The state's share may not exceed the VDOE-approved rate, and it is based on the same composite index of a locality's ability to pay as for the special education add-on.

State funding for children placed in private special education schools is provided from an interagency pool under the *Comprehensive Services Act*, which is described in more detail in the Community Living Supports chapter of this assessment. Eligible children have either been placed in out-of-home environments by a local public agency such as the courts, social services, or a school division or are at-risk for such placement. These children are also not counted toward a local school division's ADM, and the state's share of actual costs for services provided by these schools is paid through percentage reimbursement based on a locality's ability to pay. As long as a student is placed in a private facility, the school division receives no state Standards of Quality (SOQ) funding because the SOQs are public school standards.

In a 2004 report to the General Assembly, *Options to Address Salary Reimbursement to Localities for Special Education Teachers of the Visually Impaired*, the **Virginia Department for the Blind and Vision Impaired (DBVI)** called attention to the continuing problem of inadequate funding for special education teachers for children with vision impairments:

“Virginia’s school divisions receive less state general fund support for teachers of the visually impaired than they do for the other categories of special education teachers. This inequity exists because teachers of the visually impaired are funded through the Department for the Blind and Vision Impaired (DBVI) rather than the Department of Education’s (VDOE) Standards of Quality (SOQ) funding formula.”

This DBVI report found that, in state fiscal year (SFY) 2004, funding of \$4,090 per full-time-equivalent special education teacher for the vision impaired was 53 percent less than the minimum VDOE allotment for special education teachers in general. The report further noted that state general fund appropriations supporting salaries of teacher for the vision impaired had remained flat at \$509,328 per year; therefore, as the number of teachers has increased, the amount of financial assistance per teacher has continued to decrease. For SFY 2010, the state appropriation remained at this level, and according to DBVI, the situation has steadily deteriorated. The funding per full-time-equivalent special education teacher of the vision impaired has now been reduced to \$3,584, a further 12 percent decline from the SFY 2004 per teacher reimbursement.

The base amount of **federal funding** for both preschool and K-12 special education programs is determined by a formula that considers past federal funding levels, the triennial school-age census, and state poverty levels. In addition, localities may apply annually to the Virginia Department of Education (VDOE) for access to discretionary federal grant funds that promote statewide special education program improvements. These special federal funds, which may not be comingled with other funds, are used to reimburse localities for actual expenditures incurred in meeting each grant’s goals and are subject to state approval.

Local school divisions may also qualify as an approved provider of services under the joint state and federally funded Medicaid public insurance program and may seek reimbursement of the federal financial participation (FFP) from the Virginia Department of Medical Assistance Services (DMAS) for covered support services provided to eligible students. These services, which must be identified in the students’ Individualized Education Programs (IEPs), include physical, occupational, and speech therapies, nursing, psychiatric, psychological, mental health, and personal care assistance services, medical evaluations, audiology, and transportation. Reimbursements are available for students covered by Medicaid or the Family Access to Medical Insurance Securities (FAMIS) program, which are further described in the Medicaid chapter of this assessment.

As with any other publicly operated school, there is no cost to the student and his or her family for attending the preschool or K-12 programs at the **Virginia School for the Deaf and**

the Blind at Staunton (VSDB-Staunton). Costs for student attendance are paid by the state which creates a potential incentive for localities to send students with high needs out of district rather than have to pay for services provided by a private school.

The following chart shows the most recent audited budget amounts and actual expenditures for VDSB-Staunton by funding source for state fiscal year (SFY) 2009. An increase of more than 50 percent occurred from the school's SFY 2008 budget of \$8,183,683 due to the closing of the Hampton campus and consolidation of its programs with those at Staunton. Indicative of this consolidation, the number of staff positions at VSDB-Staunton grew from 143 during the 2006-2008 biennium to 190 for the 2008-2010 biennium. The school's *Strategic Plan* reports that the budget declined slightly to \$10,803,977 for SFY 2010 and will decline again to \$10,253,198 for each year of the 2010-2012 biennium.

SFY 2009 AUDITED BUDGET AND EXPENDITURES FOR VSDB-STAUTON

Source	Original Budget	Adjusted Budget	Actual Expenses)
State General Funds	\$11,024,926	\$11,872,688	\$10,919,624
Special Funds	554,647	563,147	21,016
Federal Funds	787,539	887,539	777,938
TOTAL	\$12,367,112	\$13,323,374	\$11,718,578

Source: *Department of Education Direct Aid to Public Education and Virginia Schools for the Deaf and Blind: Report on Audit for the Year Ended June 30, 2009.* www.apa.state.va.us/reports/DOE09.pdf.

In SFY 2007, before consolidation, the Staunton campus served 116 students, of whom 91 (78 percent) were residential, at an average per pupil cost of \$74,134. While the school's *Strategic Plan* lists 120 students served for the 2008-2010 biennium, the SFY 2009 audit reports service to 127 students, of whom 99 (78 percent) were residential, as of May 31, 2009, yielding a per student cost of \$92,272. For the 2010-2012 biennium, the *Strategic Plan* reports a slight increase of 122 students served, which equates to a per student cost of \$84,402 for SFY 2010. This increase in per student cost at the Staunton campus following the closing of the Hampton school was expected since that school served students with multiple disabilities and it was anticipated that those transferring to Staunton would need more intensive services.

The VSDB Foundation administers gifts, grants, and bequests to the school to support its existing and future enterprises. The State Board of Education acts as its governing board and approves its budget. The market value of the Foundation's investment portfolio declined from \$3,072,434 on December 31, 2006 to \$2,466,245 on December 31, 2008, losing \$944,304 over the course of that year. The Board's disbursements from the fund to the Staunton school for that calendar year came to \$58,463.

F. Monitoring and Evaluation of Education Services

Head Start: Each local program must develop a **Disabilities Service Plan (DSP)** that outlines strategies for meeting the special needs of children with disabilities and their families. These

plans must be approved by the federal **Administration for Children and Families (ACF)** and by the local grantee responsible for the program. The DSP must:

- Show that children with disabilities and their families are fully integrated into all components of the Head Start program and that resources are used efficiently;
- Designate a disabilities coordinator who is responsible for preparation and implementation of the plan;
- Contain procedures for timely screening of participating children and for subsequent referrals to the local education agency (LEA) for further evaluation as indicated; and
- Show both commitment and specific efforts to develop appropriate interagency agreements and to work with the LEA to ensure that service opportunities and outcomes are maximized.

The ACF reviews the performance of each Head Start program at least once every three years. The comprehensive **Program Review Instrument for Systems Monitoring (PRISM)** evaluation tool is used in the review. If deficiencies are found, the local grantee is required to develop a **Quality Improvement Plan** to bring the program into full compliance with all Head Start requirements. In addition, Head Start programs are required to develop a system for ongoing monitoring of their DSP.

Head Start programs must demonstrate that children are making progress toward legislatively mandated child outcomes. The **Phonological Awareness Literacy Screening (PALS)** is used to measure progress on literacy fundamentals and assess readiness for kindergarten. Several years ago, as part of outcome measurement, Head Start began implementation of the **Child Outcomes Framework**, which applies to children with and without disabilities, and focuses on the school readiness indicators described earlier in this chapter. According to the 2008-2009 Virginia Head Start Association *Annual Report*, the Framework is used to help programs select research-based early childhood curricula as well as the best tools for assessing child progress. Local programs staff are responsible for ensuring that the curriculum is comprehensive enough to address all of the areas of the Outcomes Framework, yet specific enough to help children achieve desired outcomes.

Comprehensive training and technical assistance (TA) is provided to local grantees throughout the Commonwealth to ensure that they are in compliance with federal Head Start regulations. As of August 2010, the Office of Head Start reports having instituted a training and technical assistance system focusing on correction of deficiencies, school readiness, and training/career development needs of Head Start staff. The system consists of:

- Six National Resource Centers that showcase evidence-based practices in content areas,
- State Training and Technical Assistance (T/TA) Centers that work with the National Resource Centers to target needs of individual states and grantees,
- Increased local grantee funding to support grantees in achieving their locally determined T/TA goals, and

- Virginia TA Network staff consisting of three early childhood education specialists who work with grantees and delegates on school readiness and training/career development needs of Head Start/Early Head Start staff and grantee specialists who work with grantees and delegates on correction of deficiencies.

Data on participation by children and families and the outcomes of specific activities must be provided to the ACF annually. According to Head Start program officials, since the program promotes inclusive practices, outcomes for children with disabilities are not reported separately from those of children without disabilities.

Preschool through K-12 Special Education: By statute and regulations, the **Virginia Department of Education (VDOE)** has the principal responsibility for monitoring the implementation of Part B of the *Individuals with Disabilities Education Improvement Act of 2004 (IDEA)* in the Commonwealth. VDOE's **Office of Federal Performance Monitoring (OFPM)** oversees special education programs and services in school divisions; state-operated programs, which include the Virginia School for the Deaf and the Blind at Staunton (VSDB-Staunton), hospitals, and juvenile detention and correctional facilities; private day schools; and children's residential facilities.

To receive Part B funding under IDEA, all local education agencies (LEAs) and state-operated programs, such as VSDB-Staunton, must have in effect and must demonstrate adherence to policies and procedures that are both consistent with federal and state regulations and are consistent with plans approved by VDOE. In the past, changes to policies and procedures had to be submitted to VDOE for approval after being adopted by local school boards or by the state-operated programs' administrators. In 2006, federal regulations implementing IDEA 2004 eliminated the requirement that states submit policies and procedures to the **U.S. Department of Education's Office of Special Education Programs (OSEP)** as part of the annual certification process. As a result, VDOE deleted its requirements for local policies and procedures to be submitted for VDOE approval through the annual report process, stating that they did so to be consistent with federal action and to provide flexibility to the LEAs. According to VDOE, no negative comments were provided on this change during the state regulations revision process. In 2009, VDOE issued a *Guidance Document for Development of Local Policies and Procedures Required for Implementation of Special Regulations in Virginia's Public Schools*. This document, approved by the Attorney General's Office, provides information about the specific policy and procedure requirements to be in compliance with federal and state implementing regulations of IDEA.

In further compliance with the new federal regulations following passage of IDEA 2004, VDOE monitoring and enforcement activities now focus on: (1) improved educational results and functional outcomes for children with disabilities and (2) ensuring that school divisions meet the program requirements under IDEA Part B, with particular emphasis on requirements most related to improving educational results for children with disabilities.

Virginia's *Special Education State Performance Plan (SPP)* evaluates the Commonwealth's efforts to implement Part B requirements and describes how it will improve such implementation. The SPP must be approved by OSEP at the federal level and measures performance in the following areas:

- Provision of a free appropriate public education (FAPE) in the least-restrictive environment;
- General supervision of special education, including Child Find, effective monitoring, the use of resolution meetings, mediation, and a system of transition services; and
- Disproportionate representation of racial and ethnic groups in special education and related services to the extent the representation is the result of inappropriate identification.

IDEA requires the state to submit an *Annual Performance Report (APR)* to OSEP detailing the progress it has made each year in meeting performance targets set forth in its SPP. OSEP also completes periodic onsite compliance reviews. After review of the APR, OSEP issues an annual "determination letter" that documents the state's overall progress in meeting the requirements of IDEA. This annual report card is used by the state to help improve education services. OSEP's last routine verification visit to Virginia was in 2009. Its last determination letter was dated January 15, 2010, and VDOE provided its response on March 11, 2010. Data and findings from VDOE's reports to OSEP and their site visits to Virginia are reported later in this section.

Since the revision of federal IDEA regulations in 2006, the state's oversight system has shifted from predominantly monitoring compliance with procedural requirements to focusing on educational benefit and student results. School divisions self-report on APR compliance indicators to VDOE's Office of Federal Performance Monitoring (OFPM), which then works with them to develop corrective action plans that address areas of noncompliance and verifies that those corrections are made within one year. In addition to providing resources and assistance to all school divisions, OFPM conducts onsite monitoring visits to between 22 and 25 school divisions per year based on a six year monitoring schedule. Adjustments to the annual selection of schools in each of the eight Superintendent's regions are made to include school divisions that fail to demonstrate substantial compliance on APR indicators. The onsite reviews determine causes of noncompliance and provide targeted assistance to school divisions with the greatest need.

The Part B *Annual Performance Report for 2008-2009*, the latest available, and the 2009 and 2010 meeting minutes for the **State Special Education Advisory Committee (SSEAC)** describe ongoing activities by VDOE to improve services and outcomes benefiting students with disabilities. Those activities include, but are not limited to:

- Improvement of monitoring processes to ensure correction of noncompliance findings within local school divisions.

- Extensive provision of training and technical assistance to school divisions statewide.
- Creation of the VDOE Office of Instructional Support and Related Services to provide state level leadership to students with low incidence disabilities and those who need significant support. This includes increased focus on meeting the needs of students with an autism spectrum disorder (ASD) through the addition of an ASD program specialist and support for a variety of initiatives relating to the providing effective services. Those initiatives include, but not limited to, creation of *Guidelines for Supporting Students with Autism*, financial and staff support to the Virginia Autism Council, and work with the Joint Legislative and Audit Review Commission on its comprehensive report on services for individuals with ASDs.
- Establishment, in 2010, of the Autism Center for Excellence, in collaboration with Virginia Commonwealth University's Rehabilitation Research and Training Center (RRTC) and School of Education. A key initiative of this center will be to work with selected school divisions to improve their capacity to provide high quality programs through job embedded professional development, an innovative support model that was first developed and implemented by Commonwealth Autism Services. Through this model, a certified behavioral analysis onsite will provide training and coaching to school staff at all levels.
- Expansion of the Transition Outcomes Project into a statewide model.
- Continued focus on self-determination for students with disabilities through the "I'm Determined" project that provides direct instruction, models, and opportunities to practice skills associated with self-determined behavior starting in elementary school and continuing throughout the student's school career.
- Continued work with school superintendents to facilitate a smooth transition from Part C early intervention to Part B special education services.
- Continued work with local school divisions on the implementation of Response to Intervention (RTI) at 15 pilot schools with positive results cited, including fewer referrals to special education and fewer behavior incidents.
- Implementation of new teacher preparation programs, including the Aspiring Special Education Leaders Program and the Vision Impairment Consortium, the latter of which was initiated with Old Dominion University, George Mason University, Norfolk State University, James Madison University, and Radford University.
- Modification of the Orientation Academy for New Special Education Administrators with events held throughout the year rather than at a single event.

As noted earlier in the access and delivery section, parents who are unable to resolve issues with the provision of special education services for their child by local school divisions through less formal means may file a complaint, request mediation, or file a due process request. VDOE's **Office of Dispute Resolution and Administrative Services** produces an *Annual Report on the Dispute Resolution Systems and Administrative Services (ARDRSAS)* that

identifies and addresses systemic compliance issues affecting local school divisions. That report (www.doe.virginia.gov/special_ed/resolving_disputes/reports/annual_report_dispute_resolutions.pdf) provides details regarding the work of the office along with important explanations and footnotes to the various statistics that are important to understanding the full complexities of the dispute resolution system. In brief, the responsibilities of the office include:

- Investigating and resolving all valid special education complaints on behalf of eligible students with disabilities when the complaint alleges a violation of applicable state and federal laws and regulations. Complaints typically involve procedural violations.
- Managing the special education mediation system, a voluntary procedure in which a neutral, impartial, trained mediator can be sought by parents or school division staff to assist in negotiations and help reestablish productive working relationships.
- Managing and monitoring the state's special education due process hearing system, an impartial procedure used to resolve disagreements over issues related to special education services that arise between a parent and a school division. Due Process requests generally relate to substantive issues regarding the identification, evaluation, or education of a child or to the provision of a free appropriate public education (FAPE) for the child.
- Coordinating revision of Virginia's special education regulations.
- Coordinating the Annual Plan process for local school divisions and state-operated programs.
- Coordinating IDEA related training initiatives and responding to inquiries regarding the application of federal and state regulations governing special education.

The *Parents' Guide to Special Education Dispute Resolution*, which was described as under development by the dispute resolution office in the 2008 edition of this assessment, has now been completed. This publication (www.doe.virginia.gov/special_ed/resolving_disputes/parents_guide_dispute_resolution.pdf) helps parents navigate the intricacies of the various dispute resolution processes, especially when they are representing their child's interests without the assistance of legal counsel.

The chart below shows the number of complaints, requests for mediation, and due process hearing requests filed by parents for each school year since 2004-2005.

DISPUTE RESOLUTION FILINGS BY YEAR

School Year	Complaints	Mediation	Due Process
2004-2005	167	133	107
2005-2006	132	125	98
2006-2007	115	129	69
2007-2008	138	138	87
2008-2009	121	105	81
2009-2010	132	119	79

Source: Virginia Department of Education: *Annual Reports of the Dispute Resolution Systems and Administrative Services*, 2005, 2006, 2007, 2008, 2009, 2010.

Overall, there has been a decline in complaints since 2004-2005, with the lowest number in 2006-2007; however, there has been much variation from year to year. The most recent data available, for school year 2009-2010, shows a nine percent increase over the previous year, to 132 from 121.

Of the complaints filed during 2009-2010, 18 of 132 were withdrawn and 11 were resolved through mediation or a settlement agreement. For the remainder, as of June 30, 2010, 78 administrative decisions were issued addressing 251 issues, and 23 cases were still pending but had not exceeded the 60-day timeline. In 171 of 251 issues addressed, the local school divisions were found to be in compliance, while 80 were found to be noncompliant. Decisions were appealed in 31 of 78 decisions, and findings were affirmed in 22 cases, remanded in one case, and reversed in one case. A split decision was rendered in three cases and one remained pending. Appeals were denied in three cases due to untimely filing.

As in previous years, the highest rate of noncompliance findings was for Individualized Education Plan (IEP) issues. Of 125 IEP issues (out of 251 total issues noted above), 28 percent regarded noncompliance. The next highest issues, although for smaller numbers, involved procedural safeguards such as prior written notice and provision of IEP progress reports.

VDOE received 13 percent more mediation requests in 2009-2010 than in 2008-2009, 119 versus 105, but that number was still lower than the highest for the period in 2007-2008. An increase in requests for mediation is a positive development, since this is a less adversarial way in which to resolve disagreements that has been highly promoted and encouraged by VDOE. By September 2010, when the 2009-2010 ARDRSAS was published, 56 of the 119 requests received that year had been resolved, 20 remained unresolved, 22 were withdrawn, and 21 were still pending. The percentage of cases resolved at the time of the ARDRSAS report declined from 70 percent, 74 of 105 cases for 2008-2009, to 47 percent for 2009-2010. In 2009-2010, 20 of the 119 mediation requests (17 percent) emanated from a due process hearing request, compared with 24 of 105 (23 percent) for the previous year. Nine of the cases emanating from a due process request in 2009-2010 were resolved through the mediation process, seven were unresolved, two were withdrawn, and two were still pending at the time of this assessment.

Mediation requests for 2009-2010 addressed 225 issues, up from 208 in the previous year. The issues addressed have remained consistent with the exception of transportation, which still represents a small number of issues brought forward but has grown from one request in 2005-2006 to ten in 2009-2010. They include the type and sufficiency of IEP services, placement, goals, staffing, evaluation and disability, discipline, and financial responsibility for programs selected by parents.

The number of due process hearing requests reported by ARDRSAS has also shown a downward trend for the past six years. Of the 79 hearing requests in 2009-2010, 60 (76 percent) were dismissed or withdrawn, 12 (15 percent) had a decision rendered after a hearing, and seven (nine percent) were still pending as of June 30, 2010. Outcome statistics for the previous school year were very similar. Regarding the cases dismissed or withdrawn, the ARDRSAS explains

that this occurs as a result of a mediation or settlement agreement or a request for withdrawal. Cases can also be closed if the hearing officer dismisses the case for other reasons, such as the expiration of the statute of limitations, failure to present proper notice, etc. In 2009-2010, nine cases were dismissed by their hearing officer.

The number and proportion of decisions rendered in favor of the local education agency (LEA) has been consistently, significantly higher than those rendered in favor of parents. In 2009-2010, of the 12 decisions noted above, only one was in favor of the parent, six were in favor of the LEA, and five concluded with a split decision. In 2008-2009, one of nine decisions was rendered in favor of the parent, and eight were decided in favor of the LEA, with no split decisions. For the last four school years (2006-2007 to 2009-2010), the highest number of decisions, 16, were rendered in 2007-2008, and again, only one was decided in favor of the parent.

Due process hearings held in 2009-2010 addressed 38 issues. IEPs, including placement and services, were the subject of 17. Five related to due process, focusing on tuition reimbursement. Four concerned discipline, and three referenced eligibility. Nine others addressed areas such as extended school year, transportation, and compensatory education.

The addition of resolution sessions to the due process hearing system was mandated in the 2004 amendment and reenactment of the federal *Individuals with Disabilities Education Improvement Act* (IDEA). School divisions must schedule a resolution session with parents to provide both parties with an opportunity to come to agreement over an issue. Both parties can waive resolution, opt for mediation, or chose to move forward with due process.

The first year of implementation of the IDEA 2004 mandate, 2005-2006, produced the highest proportion, 61 percent, of resolution sessions per due process hearings initiated. Since then, the proportion has remained stable at 56 to 57 percent. During the 2009-2010 school year, 50 of 79 due process hearings initiated (56 percent) led to resolution sessions. The first year of resolution sessions also produced the lowest proportion in which an agreement was reached, only 16 of 59 sessions (27 percent) were able to resolve differences. For 2009-2010, agreement was reached in 38 percent of resolution sessions.

The **State Special Education Advisory Committee** (State SEAC or simply SSEAC) serves as an advisor to the State Board of Education and provides additional oversight for the Commonwealth's special education system. Membership is comprised of stakeholders defined by the federal *Individuals with Disabilities Education Improvement Act* of 2004 (IDEA) and *Regulations Governing Special Education in Virginia* (8 VAC 20-80-30). The SSEAC includes parents, individuals with disabilities, advocates, and representatives of public and private schools and postsecondary education, among others. IDEA requires the SSEAC to:

- Define plans for identifying children with disabilities,
- Determine the unmet needs of children with disabilities in Virginia,
- Develop priorities and strategies for meeting identified needs of children with disabilities,

- Review and make comment on the State Improvement Plan for special education,
- Review procedures for the distribution of funds under IDEA Part B and any rules or regulations proposed by Virginia regarding the education of children with disabilities, and
- Advise the state in developing corrective action plans to address findings identified in federal monitoring reports.

In its 2007-2008 and 2008-2009 annual reports to the State Board of Education, the latest available, the SSEAC identified work on a number of issues, including seclusion and restraint in public schools, recruiting individuals to work in special education, greater involvement of constituents in the SSEAC, development of undergraduate special education licensure programs, training for school administrators, the Virginia Modified Achievement Standard Test, access to the general curriculum, youth self-determination, accessible instructional materials, and secondary transition. Unlike previous years' reports, those for 2007-2008 and 2008-2009 included few specific recommendations to the Board of Education for system improvements.

Although not mandated by the IDEA, state regulations (8 VAC 20-80-90) require that local education agencies (LEAs) establish **Local Advisory Committees**, referred to as either LACs or **local Special Education Advisory Committees (SEACs)**. These committees advise local school boards in much the same way that the State SEAC advises the State Board of Education. State-operated programs (SOPs) do not establish LACs/SEACs but in collaboration with an assigned subcommittee of the State SEAC, conduct annual reviews of their policies and procedures.

LACs/SEACs vary greatly in their operational processes and effectiveness. A change to the state special education regulations in 2009 that added a teacher to LAC/SEAC membership requirements was controversial, with most school divisions in support and many parents and advocates opposed. Public comment submitted in opposition by the State SEAC, and noted in their 2008-2009 annual report, stated that: "If a teacher is permitted to be a voting member on LACs, in smaller LACs there may be undue influence by people who are paid by the system."

As noted above, VDOE's Office of Federal Performance Monitoring (OFPM) also monitors education programs in **private residential facilities** under the applicable federal and state requirements regarding the provision of special education services. Previously, private special education day schools were licensed to operate by the **State Board of Education** under the *Regulations Governing the Operation of Private Day Schools for Students with Disabilities* (8 VAC 20-670-10). In addition, VDOE partnered with the state Departments of Behavioral Health and Developmental Services, Social Services, and Juvenile Justice to ensure implementation of the *Standards for Interdepartmental Regulation of Children's Residential Facilities (CORE)* regulations. This process has changed. The CORE regulations were repealed in favor of agency-specific regulations for targeted populations, and VDOE now monitors and issues a license to operate separate from other state licensing agencies.

This change resulted from the 2008 General Assembly's amendment, reenactment, and addition of sections to the *Code of Virginia* (22.1-323.2, 37.2-408, and 66.24, plus 37.2-408.1, respectively) relating to the regulation of group homes and residential facilities for children. The changes eliminated the *Interdepartmental Regulations* noted above and required the Departments of Behavioral Health and Developmental Services (under its former name, the Department of Mental Health, Mental Retardation and Substance Abuse Services, DMHMRSAS), Department of Social Services, and the Department of Juvenile Justice to regulate and license children's residential facilities. The bill required the Board of Education and VDOE to continue their oversight responsibilities for the educational programs at children's residential facilities.

According to information provided by VDOE, the department continues to coordinate with other licensing agencies to ensure protection and appropriate treatment and programming for children receiving out-of-home care. At the time of this assessment, new regulations for the operation of private schools for students with disabilities were under development that will provide a single set of regulations for both private day and residential schools, with a goal of greater accountability for educational programs in these settings.

As noted earlier, on July 1, 2009, the **Virginia School for the Deaf and the Blind at Staunton (VSDB-Staunton)** became an executive branch agency with a Board of Visitors in charge of school supervision, appointment and removal of officers and faculty, and certain funding initiatives. The Board of Visitors consists of 11 members, including four legislative members and seven non-legislative, citizen members. One of the non-legislative members must be a parent from the eastern region of the Commonwealth, one must be a parent from the western region, and one must be a representative of the Virginia School for the Deaf and the Blind Alumni Association. The non-legislative representatives are appointed by the Governor. A VDOE staff member, appointed by the Superintendent of Public Instruction, provides the Board of Visitors with technical assistance regarding instruction, federal and state special education requirements, and school accreditation.

Prior to their repeal described above, VSDB-Staunton was responsible for complying with the CORE regulations. The VSDB-Staunton residential program is now regulated by the Virginia Department of Behavioral Health and Developmental Services (DBHDS), while its education program remains under Virginia Department of Education (VDOE) oversight. Overall responsibility for ensuring that students are appropriately served, in compliance with state and federal regulations, rests with the school divisions that placed them at VSDB-Staunton.

Staff at VSDB-Staunton who teach students are licensed by VDOE or another licensing agency appropriate to their service delivery area and, as in public school divisions, must meet the standard of "highly qualified" under the federal *No Child Left Behind Act* of 2001. Additional information on that federal statute appears below.

According to the VSDB-Staunton's 2010-2012 *Strategic Plan*, school staff must be highly trained in the fields of deafness, blindness, and multiple disabilities. The plan notes that recruitment and retention of highly qualified staff is a continual issue due to low salaries, the

specialized qualifications required to work at the school, and heavy workloads caused by staffing shortages. The plan also reports inadequate staff levels in outreach, maintenance, housekeeping, security, and interpreters. Providing sufficient training in American Sign Language (ASL) is a further challenge. Because about 94 percent of VSDB-Staunton’s budget is spent on salaries, there are no funds available from other cost areas for pay increases that would encourage staff to remain at the school.

Accountability for the **Department for the Blind and Vision Impaired (DBVI) Educational Services** described earlier is the responsibility of the DBVI Educational Services Program Director, who is assisted by six regional managers. Each regional manager provides direct supervision for the education coordinators. The Program Director and regional managers observe and evaluate staff performance, review records, and receive input from customers and consumer groups. Corrective actions resulting from a review may include individual training, casework correction, or other personnel actions.

In addition to the federal monitoring under the *Individuals with Disabilities Education Improvement Act* of 2004 (IDEA) described at the start of this section, Virginia has significant accountability and reporting requirements under the *No Child Left Behind Act of 2001 (NCLB)*. NCLB requires schools to set annual benchmarks for achievement in reading and math leading to 100 percent proficiency by 2014. Schools, school divisions, and states that meet or exceed their annual benchmarks are rated as having made “**adequate yearly progress**” (AYP). At least 95 percent of all students must be tested, including 95 percent of students in the specific subgroups of white, black, Hispanic, students with disabilities, students with limited English proficiency, and students who are economically disadvantaged. Annual ratings are based on achievement during the previous academic year or combined achievement from the most recent years. Virginia did not make AYP in the 2009-2010 school year.

The annual *State School Report Card* provides important information on the performance of Virginia schools with respect to AYP. The report card disaggregates data by population, including students with disabilities, and includes state and school division level reports on the key indicators required under NCLB. The following table lists some key indicators of interest from the Commonwealth’s August 2010 *Report Card*.

ACADEMIC ACHIEVEMENT IN STATE ASSESSMENT TESTS, PASS RATES

ENGLISH

School Year	2006-2007	2007-2008	2008-2009	2009-2010
All Students	85%	87%	89%	89%
Students with disabilities	64%	67%	73%	73%

MATHEMATICS

School Year	2006-2007	2007-2008	2008-2009	2009-2010
All Students	85%	84%	86%	88%
Students with disabilities	62%	65%	71%	73%

Source: Virginia Department of Education: *School, School Division and State Report Card*, August 2010. <https://p1pe.doe.virginia.gov/reportcard/report.do?division=All&schoolName=Alla>.

As this table shows, performance for all students, which includes students with disabilities, has been relatively stable for the past several years but continues to be significantly higher than for the subset of just students with disabilities. The performance of students with disabilities is also the lowest among the subsets tracked, including those who are economically disadvantaged or who have limited English proficiency. Performance of students with disabilities has improved, however, over the past four years. Pass rates in English and mathematics tests rose by nine and 11 percentage points, respectively, from 2006 to 2010. The achievement gap between all students and students with disabilities, which was 21 percentage points for English and 23 for mathematics in 2006, has been reduced to 16 and 15 percentage points, respectively, in 2010.

Each year, VDOE also publishes the *Special Education Performance Report* that reports performance of students with disabilities on both OSEP and NCLB indicators. Data from the latest report published in June 2010 appears below. Not all indicators were required to be reported (N/R) for both years shown.

SPECIAL EDUCATION PERFORMANCE REPORT, OSEP AND NCLB INDICATORS

School Year	2007-2008		2008-2009	
	Target	Performance	Target	Performance
Graduation Rate:				
Regular Diploma	45%	44%	N/R	N/R
Drop Out Rates for Students				
with IEPs (grades 7-12)	1.89%	2.4%	N/R	N/R
Long-term Suspensions	12%	18%	N/R	N/R
Expulsions	8%	7.6%	N/R	N/R
Disproportionality in Special				
Education and Related Services	0%	0%	0%	0%
Disproportionality in Specific				
Disability Areas	0%	0%	0%	0%
Eligibility Timeline	100%	96.8%	100%	97.5%
Part C to Part B Transition	100%	97%	100%	99%
Secondary IEP Goals and				
Transition Services on IEP	100%	83%	N/R	N/R
Post-Secondary Outcomes:				
Employed or in School Within a				
Year of Leaving High School	60%	75.5%	N/R	N/R

Source: Virginia Department of Education: *Special Education Performance Report*, June 2010.
www.doe.virginia.gov/special_ed/reports_plans_stats/special_ed_performance/index.shtml.

Of key interest is the progress made with respect to disproportionate representation of minority students in special education. As reported in earlier editions of this assessment, baseline data for 2005-2006 showed that nine school divisions had significant disproportionality as a result of inappropriate identification of racial and ethnic groups in specific disability

categories. Some level of inappropriate identification in at least one of six designated disability categories was indicated for an additional 12 school divisions. These findings were corrected within one year of identification, and since that time, the indicator targets have been met.

The percentage of students with an IEP who graduated high school with a regular (standard or advanced) diploma within four years has remained stable. In 2006-2007, the target of 43 percent for this indicator was achieved. For 2007-2008, the target was raised to 45 percent, and while that target was not reached, performance did increase slightly to 44 percent, just missing the target. For students with disabilities, however, this indicator lags well behind the performance for all students, with and without disabilities, of whom 77 percent receive a regular diploma within four years. Students with disabilities had the lowest rate of obtaining a diploma within four years of all subgroups. The next closest was students with limited English proficiency of whom 56 obtained a regular diploma within four years. In 2007-2008, the drop-out rate for students with disabilities rose slightly to 2.4 percent from 2.3 percent the previous year. The need for more work in both of these areas is clearly indicated.

The most recent targets and performances for two other important indicators with multiple sub-indicators are listed below.

INDICATOR 3: PARTICIPATION AND PERFORMANCE IN STATEWIDE ASSESSMENTS

School Year	2007-2008		2008-2009	
	Target	Performance	Target	Performance
Divisions Meeting Adequate Yearly Progress (AYP)* for Students with Disabilities	66%	59.8%	67%	71.9%
Students with Disabilities Participation Rate for English/Reading	95%	99%	95%	99%
Students with Disabilities Participation Rate for Math	95%	99%	95%	99%
Students with Disabilities Proficiency Rate for English/Reading	77%	67%	81%	72%
Students with Disabilities Proficiency Rate for Math	75%	65%	79%	71%

*Adequate Yearly Progress (AYP) is a performance indicator under the federal *No Child Left Behind Act* that applies to all students.

Source: Virginia Department of Education: *Special Education Performance Report*, June 2010.
www.doe.virginia.gov/special_ed/reports_plans_stats/special_ed_performance/index.shtml

In 2007-2008, only 59.8 percent of school divisions achieved Adequate Yearly Progress (AYP), and the Commonwealth failed to reach its target of 66 percent, based on the performance of the previous year. For 2008-2009, however, the state exceeded its target of 67 percent, reaching 71.9 percent, reflecting a 20 percent improvement over the previous year.

Participation rates for English/Reading and Math remained stable at 99 percent from the 2006-2007 to the 2008-2009 school years, while proficiency rates showed steady progress despite missing their targets. English/Reading proficiency improved from 62 percent in 2006-2007 to 67 percent in 2007-2008 to 72 percent in 2008-2009. Math proficiency improved from 58 percent to 65 percent to 71 percent over the same period.

INDICATOR 5: LEAST RESTRICTIVE ENVIRONMENT FOR SCHOOL-AGE CHILDREN*

School Year	2007-2008		2008-2009	
	Target	Performance	Target	Performance
Students Spend 80% or More Time in the Regular Classroom	62%	57%	64%	56%
Students Spend 40% or Less Time in Regular Classroom	11%	16%	10%	16%
Students Served in Separate Public or Private Residential, Home-Based, or Hospital Facility	1%	3.5%	<1%	3.6%

*Reporting on time spent in the least restrictive environment by preschoolers receiving Part B services was not required.

Source: Virginia Department of Education: *Special Education Performance Report*, June 2010.
www.doe.virginia.gov/special_ed/reports_plans_stats/special_ed_performance/index.shtml

Virginia did not meet its targets for educating children with disabilities in the least restrictive environment, and performance actually decreased from 2007-2008 to 2008-2009. While the percentage of students spending 40 percent of their time in the regular classroom remained constant at 16 percent for both years, the percentage spending 80 percent or more of their time in the regular classroom declined slightly from 57 to 56 percent. The percentage served in separate environments also grew slightly from 3.5 percent in 2007-2008 to 3.6 percent in 2008-2009.

As noted at the beginning of this section on evaluation and monitoring of K-12 special education services, the federal **Office of Special Education Programs (OSEP)** reviews *Annual Performance Reports (APRs)* provided by the Virginia Department of Education (VDOE) and conducts periodic onsite verification visits to monitor the state's provision of services under Part B of the *Individuals with Disabilities Education Act (IDEA)*. Following its review of Virginia's APRs, OSEP can find that the state "meets requirements," "needs assistance," "needs intervention," or "needs substantial intervention." These are the same standards used by VDOE in evaluating the performance of Virginia's school divisions. OSEP found that Virginia met requirements for 2005-2006 and 2006-2007 and that it needed assistance in 2008.

OSEP's 2005 verification visit was reported in the 2008 edition of this assessment. In its May 2005 determination letter to VDOE following that visit, OSEP expressed concern that data collection by VDOE for monitoring and ensuring correction of school district compliance with IDEA was inadequate, hearing requests were not being resolved in a timely manner, and youth

with disabilities receiving special education and related services in juvenile detention facilities were excluded from the state's Part B child counts. Subsequently, those issues were resolved.

The most recent verification visit by OSEP occurred in October 2009. During that visit, they (1) analyzed the components of the state's general supervision, data, and fiscal systems to determine the extent to which they were effective in ensuring compliance and improving performance and (2) reviewed the accuracy of data submitted for selected performance indicators in the APR for the 2007-2008 school year.

In the findings from that verification visit, OSEP identified noncompliance by the state in the following areas: (1) use of percentage thresholds for identifying noncompliance, (2) the practice of finding noncompliance to be corrected without determining whether a school division was correctly implementing the specific regulatory requirements, (3) failure to consider underrepresentation when determining whether school divisions have disproportionate representation, (4) definition of significant disproportionality, and (5) the practice of calculating state-level maintenance of effort based solely upon state educational agency expenditures.

Following receipt of OSEP's "Letter of Findings," VDOE noted that some of these findings were based on the 2007-2008 school year and that corrections made in 2008-2009, prior to the verification visit, had not been recognized. As required, VDOE responded to OSEP's letter with a corrective action plan, which VDOE reports has been implemented.

Virginia's 2009-2010 APR will not be available until after the publication of this assessment. The most recent OSEP monitoring priorities, associated key federal indicators, and explanations of their progress or slippage are detailed in Virginia's 2007-2008 and 2008-2009 APRs (www.doe.virginia.gov/special_ed/reports_plans_stats/annual_performance_reports/2007-08.pdf, www.doe.virginia.gov/special_ed/reports_plans_stats/annual_performance_reports/2008-09.pdf).

G. Education Services Sources Referenced in This Chapter

Links to websites and online documents reflect their Internet addresses in March 2011. Some documents retrieved and utilized do not have a date of publication.

Websites:

U.S. Department of Health and Human Services:

Administration for Children and Families:

www.acf.hhs.gov.

Office of Head Start:

www.acf.hhs.gov/programs/ohs/

Virginia Department for the Blind and Vision Impaired:

www.vdbvi.org

Virginia Department of Education:

www.doe.virginia.gov

Dispute Resolution:

www.doe.virginia.gov/special_ed/resolving_disputes/index.shtml

Early Childhood.

www.doe.virginia.gov/special_ed/early_childhood/index.shtml

Grants and Funding.

www.doe.virginia.gov/special_ed/grants_funding/index.shtml

I'm Determined Project:

www.imdetermined.org

Monitoring:

www.doe.virginia.gov/special_ed/monitoring/index.shtml

Regulations, Laws and Policies:

www.doe.virginia.gov/special_ed/regulations/index.shtml

Secondary Transition.

www.doe.virginia.gov/special_ed/transition_svcs/index.shtml

Special Education:

www.doe.virginia.gov/special_ed/index.shtml

Special Education Child Count:

www.doe.virginia.gov/special_ed/reports_plans_stats/child_count/index.shtml

State Special Education Advisory Committee:

www.doe.virginia.gov/boe/committees_advisory/special_ed/index.shtml

Statistics and Reports:

www.doe.virginia.gov/special_ed/reports_plans_stats/index.shtml

Testing and Standards of Learning:

www.doe.virginia.gov/testing/index.shtml

Virginia Preschool Initiative Enrollment:

<http://vaperforms.virginia.gov/agencylevel/src/displaymsr.cfm?measureid=20100000.001.001>

Virginia Department of Rehabilitative Services:

www.vadrs.org

Woodrow Wilson Rehabilitation Center PERT Program:

<http://wwrc.virginia.gov/pertprogram.htm>

Virginia Head Start Association:

www.headstartva.org

Virginia School for the Deaf and the Blind at Staunton:

<http://vsdb.k12.va.us/>

Documents:

Administration for Children and Families, Administration on Children, Youth and Families.

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IV. Employment

A. Introduction

According to the U.S. Department of Labor's Bureau of Labor Statistics, the employment rate for adults ages 16 to 64 with a disability was 29.7 percent in 2009. This rate, also known as the proportion of the population employed or employment population ratio, was 77.8 percent for persons without a disability. Unemployment rates are determined based on the number of individuals who are employed or are jobless, looking for work, and available for work. That same year, unemployment rates were 15.6 percent for individuals with disabilities and 9.2 percent for persons without disabilities. The 2009 rates represented the first annual statistics available on the employment status of persons with a disability.

The Bureau of Labor Statistics obtained data to calculate these statistics using the monthly Current Population Survey (CPS) that collects employment and unemployment information from a sample of approximately 60,000 households in the United States. Beginning in June 2008, questions were added to the CPS to identify persons with a disability in the civilian, non-institutionalized population ages 16 and over. The CPS considers individuals to have a disability if they have a physical, mental, or emotional condition that causes serious difficulty with daily activities. Some highlights from the 2009 data were:

- For all age groups, the employment rate was much lower for persons with a disability than for those with no disability.
- The unemployment rate for persons with a disability was well above the rate for those with no disability.
- Nearly one-third of workers with a disability were employed part-time, compared with about one-fifth of those with no disability.

The American Community Survey, a large continuous demographic survey by the U.S. Census Bureau that profiles communities each year, also collects employment data on people with and without disabilities. In this survey, like the CPS, people are determined to have disabilities if they have long-lasting physical, mental, or emotional conditions or limitations that affect their ability to perform major life activities. Nationally, this survey reported that 6,723,694 of 19,054,587 individuals with disabilities ages 18 to 64 living in the community (35.3 percent) were employed. For the comparable population of individuals without disabilities, 126,478,646 of 170,126,637 individuals (74.3 percent) were employed. The employment rate for people with disabilities was highest in North Dakota (56.3 percent) and lowest in the District of Columbia (27.2 percent).

In Virginia, 168,577 of 440,575 individuals with disabilities (38.3 percent) were employed, compared to 3,406,679 of 4,441,890 persons without disabilities (76.7 percent). The gap between the employment rate for Virginians with and without disabilities, 38.4 percentage

points, gives Virginia a rank of 25th among the states. This gap is basically unchanged from 2007 when the employment rate for Virginians with disabilities was 36.3 percent and the rate for Virginians without disabilities was 76.9 percent, a gap of 40.6 percentage points. In, 2007, however, Virginia ranked 13th among the states, indicating that other states have moved ahead of Virginia in closing their employment gaps.

Employees with disabilities are a rich talent pool that is often overlooked. When employers hire individuals with disabilities, they discover untapped skills, talents, and abilities. Employers gain workers who are qualified, have a strong work ethic, are dependable, and are likely to stay on a long-term basis. These workers contribute to the economy, are self-sufficient, and are committed to their jobs. Furthermore, they are subject to the same performance standards as all other employees. This is true for individuals with varying levels and types of disabilities.

The *Virginians with Disabilities Act (Code of Virginia 51.5-1)* states that: “it is the policy of this Commonwealth to encourage and enable persons with disabilities to participate fully and equally in the social and economic life of the Commonwealth and to engage in remunerative employment.” Under this statute, the General Assembly directs state agencies to provide those services necessary to assure equal employment opportunity to Virginians with disabilities, and currently, there are some exciting employment initiatives in Virginia.

In collaboration with the Virginia Department of Rehabilitative Services (DRS), Virginia Commonwealth University’s (VCU) **Autism Spectrum Disorders (ASD) Career Links** initiative is conducting evidence-based research on vocational rehabilitation service models for individuals with ASD. This project examines vocational rehabilitation service delivery and employment outcomes among DRS clients with ASD, the impact of intensive community-based work experiences on the employment outcomes of youth with ASD, the postsecondary school participation and ultimate employment of college students with ASD, and the impact of personal digital assistants (PDAs) on the outcomes of individuals with ASD. More information on this research primarily targeting youth and young adults with ASD of varying levels who are unemployed, underemployed, or underserved in postsecondary education can be found at www.vcu-autism.org.

In 2009, the Virginia Department of Behavioral Health and Developmental Services’ (DBHDS) Office of Developmental Services joined the **State Employment Leadership Network**, a cross-state cooperative of agencies serving individuals with intellectual disabilities (ID) and other developmental disabilities (DD). This network helps those agencies enhance their states’ capacity to develop, implement, and support effective integrated employment initiatives that improve employment outcomes for individuals with ID/DD. In 2010, DBHDS issued a strategic plan entitled *Creating Opportunities: A Plan for Advancing Community-Focused Services in Virginia* (www.dbhds.virginia.gov/OPD-default.htm) that identifies a number of targeted initiatives that DBHDS plans to address over the next three and a half years. For example, an Employment Team representing state and local disability agencies and organizations is working on an implementation plan for the strategic initiative to create employment

opportunities for individuals receiving developmental services and supports in coordination with the Governor's Economic Development and Job Creation Commission.

The initiatives above are just a small sample of the publicly funded employment services available in Virginia to assist individuals with disabilities in acquiring the knowledge and skills required to obtain, maintain, and advance in employment. This chapter will discuss those services as well as services that educate employers about the valuable pool of workers with disabilities and assist them in making reasonable accommodations for those employees who need them.

Employment services, most of which are time-limited, encompass a wide range of activities such as vocational counseling and guidance, education, vocational training, work skills development, assistive technology, and job development and placement. These services are designed to focus on abilities and skills, rather than disabilities, and to promote choice and self-determination with respect to job training and employment options.

The employment programs and services described in this chapter are organized according to four primary programs that assist individuals with disabilities: Virginia's vocational rehabilitation programs, the Virginia Workforce Network, federal Work Incentive Programs, and Home and Community Based Services (HCBS) Waivers. The following are brief introductions to those services.

Vocational Rehabilitation: Two agencies located within the Health and Human Resources Secretariat have the lead responsibility for vocational rehabilitation services in Virginia under the federal *Rehabilitation Act* of 1973, as amended (PL 93-112). This statute authorizes grants to states for employment-related services for eligible individuals with disabilities, giving priority to those who are considered to be "significantly disabled." The **Department of Rehabilitative Services (DRS)** is responsible for providing vocational rehabilitation services for individuals with disabilities unless the individual has a primary disability of blindness, vision impairment or deafblindness. In that case, the **Department for the Blind and Vision Impaired (DBVI)** provides vocational rehabilitation services. The *Code of Virginia* (51.5-3-12) prescribes the responsibilities and duties of both departments.

The DRS mission is to work in partnership with people with disabilities and their families, as well as to collaborate with the public and private sectors, to provide and advocate for the highest-quality services that empower individuals with disabilities to maximize their employment, independence, and full inclusion into society. DRS has numerous public and private partners which include, but are not limited to: the Virginia Departments of Education, Behavioral Health and Developmental Services, and Social Services, Employment Service Organizations (also referred to as Community Rehabilitation Programs), Community Services Boards, Centers for Independent Living, local school divisions, and institutions of higher education. The federally mandated State Rehabilitation Council provides advice and guidance to DRS on its vocational rehabilitation and supported employment programs. The Employment Service Organization Advisory Council provides advice on Supported Employment Services,

and the Long-Term Employment Support Services Steering Committee provides advice and guidance on long-term support programs.

DBVI provides services for Virginians who are blind or vision impaired, including deafblind individuals, with the primary focus of assisting eligible blind citizens achieve quality employment outcomes. DBVI's mission is to empower these individuals to achieve their maximum level of education, employment, and personal independence. DBVI's partners in these efforts include individuals who are blind and vision impaired, their families and other caregivers, DRS, local school systems, Employment Service Organizations, Community Services Boards, and the Department of Behavioral Health and Developmental Services (DBHDS). DBVI also partners with the State Rehabilitation Council, the Statewide Independent Living Council, the Virginia Industries for the Blind, and the Board for the Blind and Vision Impaired.

Virginia Workforce Network: This is the "brand" name for Virginia's system of "One-Stop" career centers known as **Virginia Workforce Centers** and other activities funded under the federal *Workforce Investment Act* (WIA). The mission of Virginia's WIA program is to improve the quality of the state's workforce, reduce welfare dependency, and enhance the productivity and competitiveness of the Commonwealth. It supports workforce investment activities, through statewide and local systems, that increase employment, retention, earnings, and occupational skills of participants.

The Governor of Virginia, or a designee from the Governor's office, serves as the state's Chief Workforce Development Officer (*Code of Virginia* 2.2-435.6 and 2.2-435.7). The Virginia Workforce Council advises the Governor on workforce training matters and serves as the state's Workforce Investment Board (*Code of Virginia* 2.2-2669). The **Virginia Community College System (VCCS)** is the state agency with primary responsibility for coordinating workforce training at the postsecondary to associate degree levels, provides staffing for the Virginia Workforce Council, and administers the WIA program in Virginia.

The Virginia Workforce Network is comprised of multiple state-administered workforce development programs and services including vocational rehabilitation and the **Virginia Employment Commission (VEC)**, among others. The VEC promotes economic growth and stability by delivering and coordinating workforce services, and as specified by the *Code of Virginia* (60.2-113), its responsibilities encompass **Job Seeker and Employer Services** for all Virginians, including those with disabilities. These include policy development, job placement services, temporary income support, workforce information, and transition and training services for displaced workers. Programs administered by the federal Departments of Labor, Education, Health and Human Services, and Housing and Urban Development are required by the WIA to participate in One-Stop Workforce Centers, and participation by additional partners, such as the Virginia Department of Rehabilitative Services (DRS) and Department for the Blind and Vision Impaired (DBVI), is encouraged.

The **Disability Program Navigator (DPN)** initiative, implemented in 2005, is jointly sponsored by the U.S. Department of Labor Employment and Training Administration

(DOLETA) and the Social Security Administration (SSA). It is codirected in Virginia by VCCS Workforce Development Services and DRS. Virginia's DPN Initiative provides services and resources to the state's 15 Workforce Investment Board (WIB) areas. It has developed new and ongoing partnerships to promote seamless, comprehensive, and integrated access to services and has expanded the workforce development system's capacity to service customers with disabilities, as well as employers who hire persons with disabilities. The initiative's "Navigators" make referrals to persons with disabilities seeking workforce services and provide technical assistance to One-Stop Workforce Centers and employers on the *Americans with Disabilities Act* (ADA) and workplace assistive technology.

In October 2010, DOLETA approved a new **Disability Employment Initiative (DEI)** award to VCCS, with DRS as a sub-grant recipient. DEI will build on the strengths and lessons learned through Virginia's DPN initiative to increase employment opportunities and economic self-sufficiency of persons with disabilities, particularly adults ages 25 and over. It will also support continuation of DPN activities and best practices with a focus on youth services. Five local Workforce Investment Boards (WIBs 6, 8, 11, 13, and 14) will participate in DEI as pilot sites, employing Disability Resource Coordinators and becoming Employment Networks (ENs) under the *Ticket to Work and Work Incentives Improvement Act* of 1999 (PL 106-170). These WIBs will actively participate in the **Ticket to Work** program. Four additional WIBs (1, 3, 12, and 17) will participate as comparison sites, and all nine will participate in data collection and program evaluation.

Work Incentive Programs: The Ticket to Work mentioned above is a program of the federal Social Security Administration (SSA) for individuals who receive Supplemental Security Income (SSI) or Social Security Disability Income (SSDI) benefits. It is designed to transition individuals with significant disabilities who have been receiving these benefits back into the workforce. It helps those individuals overcome barriers, such as concerns about the loss of cash payments or health care benefits, which may negatively influence their decisions about seeking employment. It also increases the opportunities and choices for SSI and SSDI beneficiaries to obtain employment, vocational rehabilitation, and other support services from public and private providers, employers, and other organizations. An advantage of this program is that SSA does not conduct a medical review of a person receiving disability benefits if that person is using a Ticket to Work to pursue employment.

The **Work Incentives Planning and Assistance (WIPA) Program**, also from SSA, increases emphasis on work incentives, return-to-work supports, and jobs for SSI and SSDI beneficiaries. Local community organizations, known as **Work Incentive Planning and Assistance (WIPA) Projects**, help individuals who receive SSA disability benefits learn how employment can affect those benefits and provide them with information and planning services about work and work incentives.

MEDICAID WORKS is Virginia's Medicaid Buy-In Program for individuals with disabilities who are employed or who want to become employed. To remove barriers to employment, a Medicaid Buy-In Program allows working people with disabilities to participate

in their state's Medicaid program by paying a premium, if required, while earning a higher income and retaining more in savings or other resources than is usually allowed by Medicaid. As of January 20, 2011, MEDICAID WORKS was premium-free for Virginia enrollees. Continued Medicaid health care coverage as they work and save enables individuals with disabilities to gain greater independence. Additional information on Virginia's Medicaid program can be found in the next chapter of this assessment.

Home and Community Based Services (HCBS) Waivers: Three of Virginia's HCBS Waivers provide employment support services: the Individual and Family Developmental Disability (DD) Waiver, the Intellectual Disability (ID) Waiver, and the Day Support Waiver. More specific information on the services under these waivers is found later in this chapter.

B. Eligibility for Employment Services

Department of Rehabilitative Services (DRS) Vocational Rehabilitation Program: To be eligible for vocational rehabilitation services from DRS, an individual must have a physical, mental, or emotional disability that constitutes a substantial impediment to employment; require vocational rehabilitation services to prepare for, secure, or regain employment; and be able to benefit from vocational rehabilitation services. In addition the individual must be legally eligible to work in the United States and be present in the state. Individuals receiving Supplemental Security Income (SSI) or Social Security Disability Income (SSDI) benefits are presumed to be eligible for rehabilitation services if they intend to work.

The **DRS Deaf and Hard of Hearing Program** works in partnership with the Virginia Department for the Deaf and Hard of Hearing (DDHH), Department for the Blind and Vision Impaired (DBVI), and the Department of Behavioral Health and Developmental Services' (DBHDS) Program for Individuals Who Are Deaf, Hard of Hearing, Late Deafened, and Deafblind to provide vocational rehabilitation services for individuals with the disabilities just named. These four agencies have established both a Statewide Interagency Team and regional teams to address gaps in services and to strengthen agency programs. Information on related services provided by DDHH, including assistive technology, outreach, and sign-language interpreters, can be found in the Community Supports and Health chapters of this assessment.

To be eligible for vocational rehabilitation services from DRS' **Woodrow Wilson Rehabilitation Center** in Fishersville, an individual must meet the specific criteria listed below, and primary consideration is given to DRS vocational rehabilitation clients working under an Individualized Plan for Employment (IPE).

- Applicants must be medically, physically, and psychologically stable and have a favorable prognosis for completing and benefiting from the services requested. Current documentation may be requested from a physician, mental health professional, or other professional providing treatment or diagnostic services.

- Applicants with a psychiatric diagnosis must show a minimum of six consecutive months of stability in the community. Exceptions to this requirement may be considered if the applicant is willing to participate in an outpatient evaluation at WWRC to determine feasibility for services and admission contingencies.
- Applicants with a history of substance abuse must have at least six consecutive months of documented abstinence or demonstrated completion of intense substance abuse treatment and active participation in a substance abuse aftercare program. Participation in only Twelve Step support groups does not meet this requirement. As above, exceptions may be considered if the applicant is willing to participate in an outpatient evaluation at WWRC to determine feasibility for services and admission contingencies.
- Applicants' current behavior will not jeopardize the health and safety of themselves or others at WWRC and must not disrupt the rehabilitation programs.
- Applicants must be 18 years of age or older to be admitted for residential services. WWRC programs specifically targeted to youth, such as the transition programs discussed in the Education chapter of this assessment, are exceptions to this rule.
- Applicants must be willing and able to comply with WWRC community living standards (Rules & Regulations).
- Applicants must have a viable discharge plan, developed in collaboration with their referral source, for community reintegration services that address residential options as well as support service needs.
- Applicants must have an identified funding source. All funding sources (Medicare, Medicaid, Anthem, and any other third-party insurers) must be identified, even if the applicant is being sponsored by DRS.
- Applicants who have any outstanding court charges must have them settled prior to seeking admission. Those with cases pending adjudication by the judicial system will not be considered. WWRC is not an alternative placement option.

Department for the Blind and Vision Impaired (DBVI) Vocational Rehabilitation Program:

To be eligible for DBVI vocational rehabilitation services, an individual must be blind or have a visual impairment that interferes with finding or maintaining employment and require vocational rehabilitation services to prepare for, secure, or regain employment. DBVI defines blindness and visual impairment as follows:

- **Blind:** “An individual having not better than 20/200 central visual acuity in the better eye measured at twenty feet with correcting lenses or having visual acuity greater than 20/200 but with the widest diameter of the visual field in the better eye subtending an angle of no greater than twenty degrees, measured at a distance of thirty-three centimeters using a three-millimeter white test object, or a Goldman III-4e target, or other equivalent equipment. Such blindness shall be certified by a duly licensed physician or optometrist.” (*Code of Virginia 51.5-60*).

- **Visual Impairment:** “An individual with (1) 20/100 to 20/200 distance vision in the better eye with correcting glasses or a field limitation to 30 degrees or less in the better eye, if the person has been unable to adjust satisfactorily to the loss of vision and needs the specialized services available through DBVI Vocational Rehabilitation Program, or (2) night blindness or a rapidly progressive eye condition that, in the opinion of a qualified ophthalmologist, will reduce the distance vision to 20/200 or less.”
- **Deafblind:** “An individual with a combination of blindness and a chronic hearing impairment so severe that most speech cannot be understood with optimum amplification or progressive hearing loss having a prognosis leading to this condition and for whom the combination of impairments cause extreme difficulty in attaining independence in daily life activities, achieving psychological adjustment, or obtaining a vocation.”

Vocational rehabilitation services, including those provided by the **Virginia Rehabilitation Center for the Blind and Vision Impaired** in Richmond, are available to eligible individuals ages 14 or older. Services provided by other DBVI programs are available to individuals of all ages. Additional information regarding other DBVI programs and services may be found in the Community Supports and Health chapters of this assessment.

As noted above for DRS vocational rehabilitation services, individuals receiving SSI or SSDI benefits are presumed to be eligible for vocational rehabilitation services if they intend to work. They must also be legally eligible to work in the United States and be living or working in Virginia or moving to the state.

Virginia Workforce Network: The Virginia Employment Commission’s (VEC) **Job Seeker and Employer Services** are available universally to anyone eligible to work in the United States and are the same for persons with and without disabilities. There are no income, geographic or other restrictions to receiving these services.

To be eligible for **Workforce Investment Act Title I** adult programs, an individual must be at least 18 years of age, have the right to work in the United States, and be registered with military Selective Service if male. Participants in youth programs must be low-income and have at least one identified barrier to employment. Dislocated workers are those that are unemployed through no fault of their own, such as plant closures, layoff events, and other related circumstances.

Employers, workers and job seekers are all customers of the **One-Stop Workforce Centers**. This includes businesses, students, people with disabilities, veterans, Temporary Assistance for Needy Families (TANF) recipients, migrant and seasonal farm workers, unemployed, underemployed, and employed individuals. Eligibility for services, however, can vary. For example, a Supplemental Security Income (SSI) beneficiary with a Ticket to Work may be able to use the ticket for services only if his or her Workforce Center is a participant in a Ticket to Work Employment Network described in the access and delivery section later in this chapter.

There are also levels of services available through the One-Stop Workforce Centers and, depending on their needs, customers may move from one level to the next or receive services from more than one level. Core services, such as access to computers and other equipment and assistance with job search, are self-directed for all customers. Intensive training and career education is contingent upon the provider's eligibility requirements and available funding. For additional information, local One-Stop Workforce Centers should be contacted directly (www.vccs.edu/WorkforceServices/VirginiaWorkforceNetwork/tabid/693/Default.aspx).

Work Incentive Programs: To be eligible for a **Ticket to Work**, an individual must generally be age 18 or over and not have reached age 65 and must be receiving Supplemental Security Income (SSI) or Social Security Disability Income (SSDI) benefits. Exceptions and other qualifications may apply, and as manager of the program, the Social Security Administration (SSA) determines which recipients of SSI or SSDI are eligible to participate.

Work Incentives Planning and Assistance (WIPA) Programs are also available to SSI and SSDI beneficiaries ages 14 through 64. To receive WIPA services, an individual does not have to be working or even have decided to work.

Local Departments of Social Services determine who qualifies for **MEDICAID WORKS**. To qualify, applicants must meet income, asset, and eligibility requirements for the Aged, Blind, and Disabled Medicaid covered group (80 percent of the Federal Poverty Level). Current and new Medicaid enrollees who are blind or disabled, as defined by SSA, may have a total income in 2011 of no more than \$726 per month for a single individual or \$981 for a couple and resources of no more than \$2,000 if single and \$3,000 if a couple. An applicant must also be:

- ✓ at least 16 years of age and less than 65 years of age,
- ✓ employed or have documentation from an employer establishing the date when employment will begin,
- ✓ a resident of the Commonwealth, and
- ✓ a U.S. citizen, U.S. national, or qualified non-citizen.

Individuals currently receiving SSI or SSDI benefits from SSA satisfy the condition for disability. Any applicant without this SSA documentation must be evaluated by the state's Disability Determination Services program before eligibility is established. To enroll in **MEDICAID WORKS**, applicants must first establish a Work Incentive (WIN) account at a bank or other financial institution where earned income will be deposited. Additional information is available in the *MEDICAID WORKS Handbook* at www.dmas.virginia.gov/mb-proposal.htm.

To continue enrollment in **MEDICAID WORKS**, participants must continue to be disabled, employed, and less than 65 years of age and must meet earning and resource requirements. Eligibility is reviewed at least annually, and enrollees are required to inform their eligibility worker of changes that may affect their coverage, including but not limited to changes

in employer or loss of employment. Enrollees must provide periodic documentation of their employment status, employer, earned income, and WIN accounts. In 2011, MEDICAID WORKS enrollees may have annual earnings as high as \$44,340 and may keep resources up to \$32,545.

The 2011 General Assembly passed House Bill 2384 raising the maximum allowable gross earnings for MEDICAID WORKS enrollees to be “equivalent with the maximum gross income amount allowed under the *Ticket to Work and Work Incentives Improvement Act* of 1999 that does not trigger collection of mandatory premiums.” At the time of passage, this change equated to a maximum individual gross income of up to \$75,000. The bill did not change eligibility requirements for MEDICAID WORKS. At the time of this assessment, the legislation was still awaiting the Governor’s signature to become effective.

More information on any of the work incentive programs described above can be obtained from local Work Incentives Planning and Assistance (WIPA) Projects.

Home and Community Based Services (HCBS) Waivers: Specific information on eligibility for HCBS Waivers appears in the Medicaid chapter of this assessment. Individuals who have been found to be eligible for the Individual and Family Developmental Disability (DD), Intellectual Disability (ID), and Day Support Waivers may receive employment supports, including prevocational training and individual or group models of supported employment, if that service is included in their Individual Services Plans (ISPs). To qualify for supported employment services, the individual must have a demonstrated need for training, specialized supervision, or assistance in paid employment, be someone for whom competitive employment at or above minimum wage is unlikely without this support, and need ongoing support because of his or her disability. The individual’s need for special services is reassessed annually.

C. Access to and Delivery of Employment Services

Department of Rehabilitative Services (DRS) Vocational Rehabilitation Program:

Vocational rehabilitation services are delivered to eligible individuals by DRS through 36 local field offices across Virginia. Vocational rehabilitation counselors at these offices determine an applicant’s eligibility for services and work with them to develop an agreed upon **Individualized Plan for Employment (IPE)** necessary to achieve or maintain employment. Services may be provided directly by the counselors or by public and private service providers.

The IPE is reviewed at least annually and is amended as needed. Service recipients may be required to contribute to the cost of certain services based on DRS’ financial participation policy. Diagnostic, evaluation, counseling, and similar services are available at no cost to applicants and eligible individuals. Consideration of comparable benefits and alternate sources of funding may be required for certain services. Other services, such as assistive technology, are exempt from the comparable benefit requirement.

When DRS is unable to serve all eligible customers because of insufficient resources, an “**Order of Selection**,” based on relative need for services, must be implemented. When an Order of Selection is in effect, DRS must provide services for the category of individuals prioritized by that order. The highest priority is individuals with the most significant disabilities. The individual’s placement in a priority category is determined after an individual is found eligible for vocational rehabilitation services. Individuals in closed categories are provided referral services to the One-Stop Workforce Centers or other appropriate resources and are placed on a waiting list until resources allow the category to be opened.

DRS has had an Order of Selection in effect since July 1, 2004; however, in 2010, all priorities were open, and there was no waiting list. In February 2011, DRS announced in a communication to its State Rehabilitation Council that, effective March 1, 2011, a revised Order of Selection was in effect, and all priority categories would be closed. With no categories open, all new applicants determined eligible for vocational rehabilitation services will be placed on a waiting list. It is important to note that not all individuals with disabilities avail themselves of, or are eligible for, DRS services even when there is no Order of Selection in effect.

Descriptions of some specialized programs operated within the overall DRS vocational rehabilitation program follow. Additional information on them, and all DRS services, is available at www.vadrs.org or from the DRS central office or any of its local field offices.

Individuals with a serious mental illness may receive services from the DRS **Serious Mental Illness Program** staff. Individuals with developmental disabilities and substance abuse disorders are excluded from these services unless they have been diagnosed with a co-occurring serious mental illness. DRS counselors with special training in mental illness are assigned to eleven local Community Services Boards (CSBs) and provide vocational rehabilitation services for individuals from those localities that are experiencing serious mental illness.

Similarly, DRS counselors with special training in substance abuse provide vocational rehabilitation services as a part of treatment programs operated by eighteen CSBs. The DRS **Substance Abuse Program** is operated jointly with the Department of Behavioral Health and Developmental Services (DBHDS) and local CSBs. It provides vocational rehabilitation services for individuals who are actively involved in alcohol or substance abuse treatment or who have completed treatment.

In other areas of the state, services are provided to persons with serious mental illness and substance abuse problems by vocational rehabilitation counselors at local DRS field offices as part of their general caseloads. Participants in these specialized services may be referred to DRS by CSBs or directly by family members, physicians, and others. The DRS specialty counselors do not provide different services for their respective populations; rather, they have specialized technical expertise based on their experience, knowledge, and training in their specialty area.

The **DRS Deaf and Hard of Hearing Program**, an interagency partnership introduced in the eligibility section above, provides vocational rehabilitation services for persons who are

deaf, hard of hearing, late deafened, or deafblind. Ten regional vocational rehabilitation counselors and staff at Woodrow Wilson Rehabilitation Center's (WWRC) Special Population Services Unit who are fluent in American Sign Language (ASL) ensure communications access for persons who are deaf and hard of hearing. In all other respects, access to and delivery of services through this program are the same as for other DRS vocational rehabilitation services.

DRS has always had vocational rehabilitation clients who are recipients of **Temporary Assistance to Needy Families (TANF)**, but in 1998, they became an agency priority. At that time, the General Assembly appropriated funds to DRS for specialized employment services for TANF recipients that experience disabilities, and DRS has been in close partnerships and financial agreements with state and local social services agencies ever since. Currently, DRS has grant funding from the Virginia Department of Social Services (DSS) to support three vocational rehabilitation counselors with dedicated TANF caseloads, a program coordinator's position, and the purchase of case services for some eligible TANF recipients. The dedicated TANF vocational rehabilitation counselors serve Fairfax County, the City of Charlottesville and its surrounding counties, and the City of Richmond, Henrico County, and Chesterfield County, which all have a high volume of TANF cases. Clients are referred to DRS field offices statewide by their respective local DSS offices, and services are provided by first utilizing any available grant case service dollars. TANF clients are required to be gainfully employed or face the possibility of losing their DSS benefits, so DRS services are valued. General caseload counselors are strongly encouraged to work closely with the TANF recipient's case manager to gain additional insight into the individual's needs, share the cost of service provision, and coordinate services more effectively.

DRS Supported Employment Services are provided to individuals with the most significant disabilities who require ongoing workplace supports. Ongoing support services are generally provided by employment specialists who are associated with DRS approved vendors. These specialists typically provide initial job skills training on an intensive, one-to-one basis and gradually decrease supports as individuals become more proficient. Supported-employment services are usually limited in duration to eighteen months or less. After that period, if needed, the individual may transition to **Extended Employment Services (EES)** or **Long-Term Employment Support Services (LTESS)** provided through Employment Service Organizations (ESOs). Individuals may also transition to Home and Community Based Services (HCBS) Waiver supports, if applicable.

Neither EES nor LTESS are time-limited, and both enable individuals with disabilities to maintain employment. Through EES, ESOs provide structure, supervision, and supports in a facility-based (sheltered workshop) setting. LTESS, usually referred to as long-term, "follow-along" services, are provided after time-limited Supported Employment Services sponsored by DRS are completed and occur in an integrated, competitive work setting. Through LTESS, ESOs provide a full array of Supported Employment Services including individually supported, facility-based, enclave, and mobile crew models.

Before adjourning its regular session, the 2010 General Assembly passed amendments to the budget for state fiscal year (SFY) 2012 partially restoring proposed cuts in state General Funds for EES and LTESS services.

As previously indicated, the **Woodrow Wilson Rehabilitation Center (WWRC)** provides vocational rehabilitation and employment services for individuals with disabilities in both residential and outpatient settings. Once enrolled in a WWRC program, a client is assigned a WWRC rehabilitation counselor who provides case management and guidance for the client, his or her sponsor, and family while the client remains in the WWRC program. The WWRC counselor coordinates implementation of the service plan agreed upon by the individual with a disability and his or her DRS counselor prior to WWRC enrollment and approves expenditures of DRS funds for services during the client's training period. The WWRC and local DRS counselors stay in close contact throughout the client's stay and discuss any needed changes to the program of services. Throughout the program, the WWRC counselor also works closely with the client and his or her rehabilitation team to develop plans for transition back into the community at the conclusion of training.

Department for the Blind and Vision Impaired (DBVI) Vocational Rehabilitation Program:

Eligibility is determined and vocational rehabilitation services are delivered through six regional DBVI offices across the state. Additional prevocational services are provided in a residential setting at the **Virginia Rehabilitation Center for the Blind and Vision Impaired (VRCBVI)** in Richmond, and in some cases, when a blindness center program in another state best meets an individual's needs, DBVI arranges and pays for this service. DBVI operates a Library and Resource Center adjacent to VRCBVI and has affiliated libraries at other locations statewide. In 2010, **Virginia Industries for the Blind (VIB)** operated two manufacturing facilities in Richmond and Charlottesville and had 17 service and supply operations across the state, including 11 office supply stores in federal government buildings and on military bases. DBVI uses federal funds to purchase fee-based supported employment services from a statewide network of contracted vendors. There were 67 contracted vendors at the time of this assessment, but their number and location changes from year to year.

Procedures for access and delivery of DBVI vocational rehabilitation services are similar to those described above for the Department of Rehabilitative Services (DRS). Vocational rehabilitation counselors partner with individuals who are blind or vision impaired, their families, and service providers to develop and implement an Individualized Plan for Employment (IPE) based on the individual's abilities, needs, and choices. IPEs are reviewed at least once a year and are updated as appropriate.

Diagnostic evaluation, guidance and counseling, and similar services are free of charge for eligible applicants. Other services may be provided based on financial need, and a service recipient's financial contribution may be based on his or her resources. Consideration of comparable benefits and alternate funding sources are required for most services. Guidance and counseling, evaluation, and assistive technology services are among those that do not require comparable benefits consideration.

An “Order of Selection,” which restricts services to certain categories of individuals may be implemented when DBVI’s resources are insufficient to serve all eligible individuals. DBVI’s Order of Selection has three categories based on severity of disability. Since January 2010, all three categories have been open, and DBVI has been serving all individuals who met eligibility criteria.

Details on access to and delivery of services vary by program. Specific information may be obtained at www.vdbvi.org or by contacting the DBVI central office in Richmond or any of its six regional offices. Additional information on DVBI programs related to Community Supports and Health services can be found in those chapters of this assessment.

Virginia Workforce Network: Individuals, with and without disabilities, may access the Virginia Employment Commission’s (VEC) **Job Seeker Services** through the VEC website or by visiting VEC offices or One-Stop Workforce Centers. (Some VEC offices are also One-Stops.) Numerous local, state, and national databases of available jobs may be searched through the website, and it also allows users to access the application for State of Virginia positions and to post a resume online where it can be reviewed by potential employers.

In state fiscal year (SFY) 2010, VEC reported that a total of 14,614 “participants” with self-declared disabilities registered in their job services database, and 5,767 of them were referred to employment. During that same period, staff-assisted services were provided to 11,593 individuals with disabilities. Of these, 3,591 received career guidance, 4,780 participated in job-search activities, and 5,362 were referred to *Workforce Investment Act* (WIA) services. In all, 4,046 individuals with disabilities who received services from VEC entered employment during the year.

Multiple **One-Stop Workforce Centers**, operating in 15 local Workforce Investment Board areas across the state, simplify access by bringing employment services from multiple providers together under one roof. Each One-Stop provides a single point of access for a wide array of job training, education, and employment services designed to meet the unique needs of their local community. One-Stops also provide employers with a single point of contact where they can list job opportunities and provide information about current and future skills need by their workers.

The WIA requires that One-Stop customers with disabilities have equal access to services and that One-Stops be physically and programmatically accessible. During SFY 2010, six percent of new enrollees in WIA Title I programs (699 out of 11,007) identified themselves as having a disability. Self-reporting is the only manner in which disability information is captured, and this data represents only one of multiple programs operating within the One-Stop system.

The **Disability Employment Initiative (DEI)** and **Disability Program Navigator (DPN)** projects collaborate to support One-Stop Workforce Centers by coordinating services and resources for One-Stop staff and partners, persons with disabilities, and employers who hire them. There are currently nine Disability Program Navigators providing services to all 15

Workforce Investment Board areas. The Navigators do not work directly with individuals with disabilities; instead, they focus on developing new and ongoing partnerships to achieve seamless, comprehensive, and integrated access to services, creating systemic change, and expanding the workforce development system's capacity to serve customers with disabilities as well as their employers.

Work Incentive Programs: The Social Security Administration (SSA) provides eligible recipients of Supplemental Security Income (SSI) or Social Security Disability Income (SSDI) benefits with a **Ticket to Work** that they can use to obtain services from **Employment Networks (ENs)**. ENs are awarded unlimited, noncompetitive contracts by the SSA to provide those services through an ongoing, open-ended Request for Proposal process. Any agency or political subdivision of a state or private entity that takes responsibility for the referral, coordination or delivery of services is eligible to apply to be an EN. Applicants may be a single entity, a partnership, an alliance of public or private entities, or a consortium of organizations that combine resources and collaborate to serve individuals within the Ticket to Work program.

Participation in the Ticket to Work program is flexible and voluntary; participation by SSI and SSDI beneficiaries is not mandated. In most cases, ENs can choose the services they want to provide, where they will be provided, and to whom. "Ticket Holders" may contact more than one EN to discuss services, and once an agreement has been reached between a Ticket Holder and an EN, they work together to develop and implement a plan that will help the individual reach his or her employment goal. If a Ticket Holder becomes dissatisfied with the chosen EN, he or she can select another from which to obtain services.

As of November 1, 2010, there were 278,874 Ticket Holders in Virginia, and 64 ENs providing services in Virginia. Twenty-six of those ENs are based in the state, and the remaining 38 are located out-of-state across the nation. There are 597 Tickets assigned to 16 of the ENs that serve Virginia, and another 8,306 Tickets are in use with Virginia's Department of Rehabilitative Services (DRS) and Department for the Blind and Vision Impaired (DBVI).

Information on work incentives and related benefits planning assistance can be obtained from Community Work Incentive Coordinators employed by **Work Incentive Planning and Assistance (WIPA) Projects**. The goal of the WIPA Program is to enable SSI and SSDI beneficiaries with disabilities, including transition-to-work youth, to make informed choices about work and to take advantage of the many work incentives available to them. WIPA services are available in every state and U.S. territory. In Virginia vaACCSES (Virginia Association of Community Rehabilitation Programs) and the Endependence Center, Inc., are WIPA Projects.

As noted in the eligibility section of this chapter, local WIPA Programs can provide information on Virginia's **MEDICAID WORKS** program. To apply for MEDICAID WORKS, individuals should contact the Department of Social Services in the city or county where they live. A list of offices can be found at www.dss.virginia.gov/localagency.

D. Available Employment Services

Department of Rehabilitative Services (DRS) Vocational Rehabilitation Program: DRS vocational rehabilitation counselors work with a service recipient and providers to determine which services will meet the recipient's needs and to develop and implement an **Individualized Plan for Employment (IPE)**. Services identified in the IPE may include:

- Vocational and career guidance and counseling;
- Evaluations to determine vocational rehabilitation needs;
- Job and behavioral skills training and postsecondary education;
- Job search and placement assistance;
- Communication accommodations, when they are not available from another legally obligated source;
- Assistive telecommunications, sensory, and other technological aids and devices;
- Rehabilitation technology services, including assistive technology devices, as well as home, vehicle, and workstation modifications;
- Tools, equipment, and occupational licenses not typically provided by an employer;
- Transportation and personal assistance services needed to participate in DRS services;
- Medical services not otherwise covered by insurance that are needed to be employed;
- Unpaid work experience; and
- Postemployment services.

The list above is not all inclusive. Additional services may be provided as required by an individual's IPE, and services vary between programs, as described below.

DRS counselors in the **Serious Mental Illness Program** and **Substance Abuse Program** provide services in ways that respond to the special needs of their respective target populations. Drawing on their specialized training and expertise, these vocational rehabilitation counselors partner with local Community Services Boards (CSBs) to focus services on vocational development, work habits, job readiness, and employment follow-along.

In addition to providing direct services for eligible individuals, vocational rehabilitation counselors in the DRS **Deaf and Hard of Hearing Program** are involved in community outreach and education, providing technical assistance to organizations involved with job training, job placement, and employment of persons with hearing loss.

To help them sustain employment once their DRS cases are closed, participants in the **Temporary Assistance for Needy Families (TANF) Program** work with both DRS vocational rehabilitation counselors and local social services caseworkers. DRS counselors coordinate their

vocational rehabilitation services while social services caseworkers assist them with other transportation, child care, food stamps, and other benefits and supports.

Specialists who work for DRS approved vendors provide ongoing **Supported Employment Services** including job-site training, transportation, family supports, and other services necessary to provide and maintain employment for persons with severe disabilities in integrated and competitive work settings. Initial supports must include at least twice-monthly contacts between a specialist and supported employee and, to create a system of natural supports within the workplace and community, may also include services provided by skilled job trainers, co-workers, or other qualified individuals.

To ensure job retention in supported employment placements, DRS may use funds from **Long-Term Employment Support Services (LTESS)** to purchase ongoing support services. LTESS job coaches provide direct, face-to-face supports with supported employees and their employer, then follow up at least monthly with telephone calls and other communications to ensure job retention and compliance with supported employment program requirements.

In 2007, DRS developed and implemented the **Work Incentive Specialist Advocates (WISA)** program to augment the **Work Incentives Planning and Assistance (WIPA) Program** and increase the use of existing Social Security Administration (SSA) work incentives by vocational rehabilitation services recipients in Virginia. Forty WISAs provide assistance to Ticket to Work recipients who are eligible to use work incentive programs such as Medicaid While Working (SS11619b), Student Earned Income Exclusion, Impairment Related Work Program, and the Plan for Achieving Self-Support. To date, there have been 77 WISA authorizations for vocational rehabilitation services recipients.

DRS also spearheads a collaborative project funded by state agencies and grants that continues to update and customize the **WorkWORLD™ Decision Software**. Created by the Virginia Commonwealth University Employment Support Institute, the WorkWORLD software and online program for personal computers helps people with disabilities, advocates, benefit counselors, and others explore and understand how best to use various federal and state disability and benefit programs. The program automates computation of benefits, taking into account the complex interaction of income, benefit programs, and work incentives. Its computer-help system and query format help professionals and consumers understand the positive results and potential challenges of choosing to go to work. All Virginian residents can request a free copy of WorkWORLD at www.workworld.org, and registered users are notified when updates have been made to the software, typically two or more times per year as regulations change. Support for WorkWORLD has been provided by the Department of Medical Assistance Services Medicaid Infrastructure Grant (MIG), Department for the Blind and Vision Impaired, Virginia Board for People with Disabilities, Department of Social Services, Department of Behavioral Health and Developmental Services, and Department of Education.

The ultimate goal for each student at **Woodrow Wilson Rehabilitation Center (WWRC)** is the successful application of independent-living and work skills in his or her home

community. Following initial student and sponsor consultations, WWRC Vocational Evaluation Services offers a comprehensive and systematic process to identify and assess vocational interests, abilities, strengths, weaknesses, aptitudes, and functional limitations related to a student's preferred rehabilitation and employment goals. The evaluation report is used to develop a holistic service plan that will maximize the student's potential for successful, sustained employment.

While not strictly an employment program, the WWRC **Life Skills Transition Program**'s pre-employment activities build independent-living skills needed to maintain successful employment. It is part of a comprehensive approach to teaching individuals the job of daily life and living with others within WWRC's living and learning residential environment. The program takes advantage of the social aspects of campus life and provides activities on and off campus to assess needs and provide instruction across five domains:

- Pre-employment skills (basic work behaviors, attitudes, and habits; job seeking skills; basic customer service and effective communication with others; and vocational exploration),
- Basic workplace literacy (reading, math, GED assessment, and skill development),
- Interpersonal skills (disability awareness, self-advocacy, interpersonal communication, initiative and dependability, anger management, conflict resolution, self-esteem, and self-confidence),
- Independent-living skills (money management, clothing care, time management, route-finding and information-seeking, personal health care, and healthy relationships), and
- Leisure skills (exploration of interests and community resources).

WWRC **Vocational Skills Training Programs** prepare individuals with disabilities for competitive entry-level employment in more than 100 occupational career fields. Training is offered onsite at WWRC, through the community-based External Training Option Program in surrounding geographic locations, and through distance education courses for selected information technology careers. A student internship program provides opportunities to determine if trainees are job-ready, and academic support services, such as GED preparation and trade-related academic instruction, are also available.

To promote positive work environments and change negative attitudes toward people with disabilities in the workplace, DRS staff at WWRC conduct **Corporate Disability Awareness Training** for employers. These no-cost programs dispel misconceptions and teach best practices for working with people who have disabilities. Topics covered include individual attitudes and perceptions toward people with disabilities, historical and societal perspectives, research and statistics, the *Americans with Disabilities Act* (ADA), resources for more information, and practical tips on interviewing, accommodating, and communicating with employees with disabilities.

Department for the Blind and Vision Impaired (DBVI) Vocational Rehabilitation Program:

The basic list of vocational rehabilitation services and supports described above for the Department of Rehabilitative Services (DRS) are also provided by DBVI. Other services provided by DBVI include independent-living skills training specific to its target populations and specialized equipment to enhance personal responsibility and independence. DBVI helps people with partial sight learn to fully utilize their remaining vision, creates employment for individuals with vision impairment, and provides special library materials in recorded and other accessible formats.

Services provided at the **Virginia Rehabilitation Center for the Blind and Vision Impaired (VRCBVI)** in Richmond include prevocational training in personal adjustment and independent-living skills, use of adaptive computer equipment, and preparation for competitive employment. VRCBVI also provides vocational training that focuses on employment opportunities as customer service representatives, and it evaluates trainees' potential for employment as vending stand operators. Participants in residential programs typically remain at the Center for three to four months, but the training period is flexible and based on need.

As noted earlier, the **Virginia Industries for the Blind (VIB)** operates numerous small businesses across the state and hires blind individuals whom it has trained to work in these enterprises. Employment opportunities may exist at VIB manufacturing facilities in Richmond and Charlottesville or in one of 17 VIB's satellite operations that include six service operations, such as switchboard operations, contract management services, and court debt collections, and 11 office supply stores on military bases and in federal government buildings. The **Randolph-Sheppard Program** trains food service managers for job placement in vending facilities across the state, including VIB satellite sites and Business Opportunities for the Blind (BOB) operations. Collectively, these opportunities generate jobs for blind workers in areas where they rarely existed in the past, and it is anticipated that such opportunities will continue to increase.

Transition Services: In addition to the vocational rehabilitation services described above, both the Department of Rehabilitative Services (DRS) and Department for the Blind and Vision Impaired (VBPD) provide services for students transitioning from school to postsecondary activities, including higher education and employment. Transition consultation is provided through cooperative agreements between DRS and DBVI and public school divisions, referred to as **local education agencies (LEAs)**. LEAs have primary responsibility for transition services under the federal *Individuals with Disabilities Education Improvement Act (IDEA)*. A student who is found eligible to receive vocational rehabilitation services must be provided those services in accordance with an Individualized Plan for Employment (IPE), just as any other vocational rehabilitation client.

Additional information on the roles of DRS and DBVI in planning for and providing transition services may be found in the Education chapter of this assessment. Since DBVI's role in coordinating education services for students with visual impairments begins well before the start of transition services, information on related vision services may also be found in the Early Intervention chapter of this assessment.

Virginia Workforce Network: A range of services to improve job search skills and to bring workers and employers together are provided by the **Virginia Employment Commission (VEC)**. **Job Seeker Services** include registration for job fairs that build job search skills, referrals to job training, employment workshops, resource rooms and support materials, job referral and placement, labor market information, and tools that help job seekers assess their job skills. The **Virginia Workforce Connection** is a new web-based, virtual One-Stop system containing a wealth of employment and labor market information with access to thousands of available jobs.

VEC **Employer Services** staff help employers find qualified workers by screening and referring applicants for job vacancies and by coordinating or providing interview facilities. They refer employers to customized training programs and provide information and guidance on starting or expanding businesses and improving employee retention, as well as labor markets, salaries, and other workforce issues. VEC also provides information on workplace accommodations and tax credits for hiring new employees with disabilities. It also administers the Work Opportunities Tax Credit, *Trade Act* Assistance, Agricultural Labor Certification, the Migrant and Seasonal Farmworkers Program, and Veterans' Services.

Multiple agencies partner to provide services through **One-Stop Workforce Centers**. Core services include public outreach; initial assessments of workers' skill levels, aptitudes, abilities, and supportive service needs; job search and placement assistance; career counseling; various group workshops; and labor market information. More intensive services can include comprehensive and specialized assessments, development of individualized employment plans, individual and group counseling and career planning, case management for participants seeking training services, and short-term prevocational services. For those still unable to find employment, direct occupational training services are available. Additional information is available at <http://myfuture.vccs.edu/WorkforceServices/VirginiaWorkforceNetwork/tabid/693/Default.aspx>.

Virginia's **Disability Employment Initiative (DEI)** and **Disability Program Navigator (DPN)** projects collaborate with One-Stop Workforce Centers, their partners, local businesses, human resource professionals, and community-based organizations to ensure that individuals with disabilities have equal access to the workforce system in their pursuit for employment. The *Employment Resource Guide*, developed by the DPN initiative and its partners, contains information on statewide resources including job/career, employer, and agency websites. Complementary *Quick Reference Guides*, also collaboratively produced by the DPN initiative, identify local education and training resources as well as other information needed to get a job or find a new career. Both guides are available at <http://myfuture.vccs.edu/Default.aspx?tabid=789>. Disability Program Navigators are also responsible for the following:

- Guiding One-Stop staff in helping people with disabilities access and navigate the complex provisions of programs affecting their ability to secure or retain employment.

- Developing and enhancing partnerships of One-Stops, service agencies, and community organizations to achieve integrated services and systemic changes that expand the One-Stops' capacity to serve customers with disabilities.
- Providing One-stop staff, partner agencies, and employers with training, educational materials, and technical assistance on disability etiquette, types of assistive technology available for individuals with disabilities, additional services offered by community organizations, and other topics.
- Assisting One-Stops, their partners, and employers in solving accessibility problems, including arranging for special assistance from appropriate agencies such as the Departments for the Blind and Vision Impaired (DBVI) and for the Deaf and Hard of Hearing (DDHH).
- Facilitating the transition of youth who are in school or out of school from to employment and economic self-sufficiency.
- Conducting outreach to agencies or organizations that serve people with disabilities.
- Conducting outreach to employers that dispels myths regarding employees with disabilities and to both employers and employees about incentives for hiring individuals with disabilities and making reasonable workplace accommodations.

As previously mentioned, the DEI project builds on the services and best practices of the DPN initiative with a focus on adults with disabilities ages 25 and over, including veterans and recipients of Temporary Assistance for Needy Families (TANF) benefits. The DEI project will enhance accessibility at the pilot One-Stop Workforce Centers using strategies such as accessibility surveys, video phones, and assistive technology kits and business workstations; promote employer outreach to Universal Design consultants and their participation in the Virginia Workforce Network; and encourage asset development strategies and the use of the Ticket to Work program by recipients of Supplemental Security Income (SSI) or Social Security Disability Income (SSDI) benefits.

Work Incentive Programs: A **Ticket to Work** may be used to obtain vocational rehabilitation, employment services, or a job from participants in **Employment Networks (ENs)**. “Ticket Holders” are also eligible for extended Medicaid insurance coverage and benefits planning assistance, including how to utilize work incentive benefits most effectively. EN participants vary, but include state vocational rehabilitation agencies and other providers of rehabilitation services for persons with disabilities, One-Stop Workforce Centers, employment agencies, state and local government human services providers, and other public and private entities. The specific services available from individual ENs varies widely.

Work Incentives Planning and Assistance (WIPA) Projects engage in ongoing outreach efforts to identify prospective Ticket to Work beneficiaries. The Community Work Incentive Coordinators employed by WIPA Projects assist these individuals in obtaining benefits and making the best use of them by:

- Providing information on how part-time, full-time, or seasonal work would affect individual disability benefits and other benefits received from federal, state, and local programs;
- Providing information on how work affects health care benefits, such as being the primary contact for Virginia's MEDICAID WORKS buy-in program;
- Providing information on work incentives by the Social Security Administration (SSA) and other sources;
- Discussing individual employment goals and helping identify resources and services to overcome possible barriers to reaching them;
- Helping individuals plan how to use work incentives or other benefits to successfully return to work and providing follow-along assistance once they are working to monitor work incentives and ensure compliance;
- Working with local Social Security offices to implement needed work incentives; and
- Helping individuals use their Tickets to Work and find appropriate Employment Networks.

In addition to the **MEDICAID WORKS** program discussed earlier, there are other incentives available that enable individuals to work and maintain critical benefits. **Section 1619 (a) and (b) of the Social Security Act** allow a working Supplemental Security Income (SSI) recipient to earn income at the substantial gainful activity level while receiving both a SSI payment and Medicaid at no cost, with 1619 (b) status occurring when the income level eliminates a SSI cash benefit but Medicaid eligibility is retained at no cost to the recipient. Another incentive, the **Plan for Achieving Self-Support (PASS)**, is an earned income and resource exclusion that allows a person with a disability receiving SSI benefits to set aside income or resources to reach an occupational goal. The **Impairment Related Work Expense (IRWE)** incentive allows an individual to deduct certain work-related items and services that are needed to enable the SSI beneficiary to work.

In calendar year 2009, there were 144,448 Virginians with disabilities receiving SSI benefits, and 86,549 were of working age, 18 to 64 years. Of those, only 7,023 (8.1 percent) were working, a slight decline from 7,198 in 2006. Of those working, 3.3 percent participated in the Section 1619 (a) incentive program, 29.2 percent participated in the Section 1619 (b) program, 0.2 percent (*i.e.*, two-tenths of one percent) participated in the PASS program, and 4.2 percent participated in the IRWE program. In June 2010, there were 24 enrollees in Virginia's MEDICAID WORKS program.

Home and Community Based Services (HCBS) Waivers: **Prevocational services**, which are not job task oriented, may be available through the Intellectual Disability (ID) and Day Support Waivers. These services provide training and assistance that prepare an individual for paid or unpaid employment. They teach fundamental skills such as accepting supervision, getting along with co-workers, and using a time clock. To be covered, the individual's assessment and service plan must clearly reflect the individual's need for this training and support.

The Individual and Family Developmental Disability (DD), ID, and Day Support Waivers may provide **supported employment (SE)** services. Supported employment can be provided via a group or individual model. It includes training in specific skills related to paid employment and the provision of ongoing or intermittent assistance and specialized supervision to enable an individual with a disability to maintain paid employment. The group model provides continuous staff support for eight or fewer individuals with disabilities in an enclave, work crew, or bench work/entrepreneurial setting. The individual model involves intermittent, one-on-one support by a job coach for an individual with disabilities in a community business after an initial intensive period of on-the-job training.

E. Cost and Payment for Employment Services

Vocational Rehabilitation Services: The Department of Rehabilitative Services (DRS) and the Department for the Blind and Vision Impaired (DBVI) receive state and federal funds to support vocational rehabilitation activities. Federal funds are provided by the **Rehabilitation Service Administration (RSA)** within the U.S. Department of Education. RSA provides grant funds both on a formula and on a discretionary basis. *Federal Rehabilitation Act* Title I and Title VI grant programs, which provide funds for employment related services for individuals with disabilities, require state matching funds. State General Funds supply this match, underwrite administrative costs, and pay for various DRS state-funded programs such as Personal Assistance Services, Long-Term Rehabilitation Case Management Services, Long-Term Employment Support Services, and others. DRS also receives federal Title VI funds for Supported Employment. Long-term follow-along funding is distributed among Employment Service Organizations (ESOs) that are approved for Supported Employment Services and Extended Employment Services, based on utility and formula.

Between 2007 and 2010, there was an overall increase of 16 percent in the number served by DRS vocational rehabilitation services, from 24,504 to 28,316. During that same period, total funds expended by DRS increased by 13 percent, from \$62,201,536 to \$70,310,835. Federal funds were the primary source for this increase. This pattern was not typical for all programs. For example, from 2007 to 2010, the DRS Deaf and Hard of Hearing Vocational Rehabilitation Program's funding declined by 19 percent, from \$2,174,818 to \$1,755,330, despite a ten percent increase in the number served, from 1,515 to 1,635.

The table immediately below provides some details about the number of participants, funding amounts and sources, and per capita costs for the DRS vocational rehabilitation

programs described in this chapter during state fiscal year (SFY) 2010. Costs for the DRS **Work Incentive Specialist Advocates Program** funded by the federal Centers for Medicare and Medicaid Services (CMS) through a Medicaid Infrastructure Grant to the Virginia Department of Medical Assistance Services were not available. Explanatory notes on other programs appear at the end of the table.

**DEPARTMENT OF REHABILITATIVE SERVICES (DRS) EMPLOYMENT SERVICES
FOR STATE FISCAL YEAR (SFY) 2010 BY PROGRAM OR SERVICE**

Number Served	Waiting List	State Funds	Federal Funds	Other Funds	Total Funds	Per Capita Cost
DRS Vocational Rehabilitation (VR) Program ^A						
28,316	36	\$8,926,341	\$61,384,494	\$0	\$70,310,835	\$2,483
Services for Individuals with Serious Mental Illness ^B						
1,346	0	\$579,861	\$0	\$0	\$579,861	\$431
Substance Abuse Services ^C						
3,256	0	\$1,128,003	\$0	\$396,515	\$1,524,518	\$468
Deaf and Hard of Hearing (DHH) Program ^D						
1,635	2	\$40,655	\$1,714,675	\$0	\$1,755,330	\$1,074
Temporary Assistance to Needy Families Program ^E						
439	0	\$0	\$601,020	\$0	\$601,020	\$1,369
Supported Employment ^F						
3,817	0	\$0	\$665,519	\$0	\$665,519	\$174
Extended Employment Services						
512	0	\$2,714,268	\$0	\$0	\$2,714,268	\$5,301
Long-Term Employment Support Services						
2,576	0	\$4,903,222	\$0	\$0	\$4,903,222	\$1,903
Woodrow Wilson Rehabilitation Center (WWRC) ^G						
3,074	400	\$5,286,242	\$264,517	\$18,287,536	\$23,838,295	\$7,755

- A. Figures for the VR Program and all other DRS programs overlap because persons who apply for vocational rehabilitation services also receive diagnostic testing when they apply. Funding includes personal, non-personal, and case service expenditures.
- B. This grant funding from the Department of Social Services is for personal services. Client case services are paid from *Federal Rehabilitation Act*, Title I, Section 110 grant funds.
- C. This funding is for personal services. Client case services are paid from federal Section 110 grant funds.
- D. Figures for the DHH Program may contain duplicates because clients may receive other DRS services. Costs for the DHH Program include only case services dollars.
- E. Funding is for personal and case services, some of which also includes federal Section 110 grant funds.
- F. This is Federal Title VI funding. Federal Title I grant funds are also utilized for SE services.
- G. WWRC total and per capita costs cannot be determined by program area because of the way operating budgets are implemented in a comprehensive rehabilitation center. Total and per capita costs across all WWRC services are shown. Capital expenditures to maintain the campus are funded in a separate budget and not shown.

Source: Department of Rehabilitative Services.

The number served by DBVI vocational rehabilitation services rose from 24,504 in 2007 to 32,141 in 2010, a 31 percent increase. For that same period, total expenditures rose from \$62,201,536 to \$70,310,835, an increase of 13 percent. Additional federal funding was the primary source for this increase as well.

The next table provides some details about the number of participants, funding amounts and sources, and per capita costs for the DBVI vocational rehabilitation programs described in this chapter during federal fiscal year (FFY) 2010. This includes services provided at the Virginia Rehabilitation Center for the Blind and Vision Impaired (VRCBVI) in Richmond.

**DEPARTMENT FOR THE BLIND AND VISION IMPAIRED (DBVI) EMPLOYMENT SERVICES
FOR FEDERAL FISCAL YEAR (SFY) 2010**

Number Served	Waiting List	State Funds	Federal Funds	Other Funds	Total Funds	Per Capita Cost
DBVI Vocational Rehabilitation (VR) Services						
581	0	\$2,462,658	\$2,463,229	\$0	\$4,925,887	\$8,478

Source: Department for the Blind and Vision Impaired.

Virginia Workforce Network: The U.S. Department of Labor provides funds under the federal *Wagner-Peyser Act* to support the Virginia Employment Commission's Unemployment Insurance program and **Job Seeker and Employer Services**. Information on the cost of services for persons with disabilities is not tracked separately. The U.S. Department of Labor also provides funding for the **Disability Employment Initiative** and funds the **Disability Program Navigators** jointly with the Social Security Administration.

Implementation of the *Workforce Investment Act (WIA)* is supported by federal funds received from the U.S. Department of Labor as well. For federal fiscal year (FFY) 2009, \$19,561,386 were expended to provide services for more than 18,000 Virginians, with and without disabilities. Costs were not tracked separately for participants with disabilities.

Work Incentive Programs: The national Social Security Administration (SSA) funds the **Ticket to Work** program, and specific information on expenditures in Virginia is not available. SSA also makes grant awards for community **Work Incentives Planning and Assistance (WIPA) Projects** covering a five year period; however, recipient organizations must submit annual requests for continuation of funding. From November 1, 2009, through October 31, 2010, the WIPA Program served 2,581 individuals in Virginia and did not have a waiting list. This represented a 75 percent increase over the number service during the same period in 2006-2007, despite flat funding from SSA for the past six years. Federal funds covered the full \$450,000 cost for WIPA Projects in Virginia, at an approximate cost of \$174 per participant. Costs for the **MEDICAID WORKS** program are covered along with other Medicaid expenditures in the next chapter of this assessment.

Home and Community Based Services (HCBS) Waivers: The table below provides some details about the numbers served, funding sources and amounts, and per capita costs for prevocational and supported employment services provided under HCBS Waivers during state fiscal year (SFY) 2010. The Individual and Family Developmental Disability (DD) Waiver is administered by the Virginia Department of Medical Assistance Services (DMAS), and the Intellectual Disability (ID) and Day Support Waivers are administered by the Virginia Department of Behavioral Health and Developmental Services (DBHDS).

Combined spending for prevocational and supported employment services under all three HCBS Waivers rose by 42 percent from \$13,325,683 in 2007 to \$18,903,763 in 2010. The number of individuals receiving these services under HCBS Waivers rose by 43 percent from 1,216 to 1,738 during that same period.

**PREVOCATIONAL AND SUPPORTED EMPLOYMENT SERVICES
PROVIDED UNDER HOME AND COMMUNITY BASED SERVICES (HCBS) WAIVERS
FOR STATE FISCAL YEAR (SFY) 2010 BY PROGRAM OR SERVICE**

	Number Served	State Funds	Federal Funds	Other Funds	Total Funds	Per Capita Cost
<u>Department of Medical Assistance Services (DMAS)</u>						
Individual and Family Developmental Disability (DD) Waiver						
Prevocational						
Services	8	\$22,353	\$35,843	\$0	\$58,196	\$7,275
Supported						
Employment	11	\$52,261	\$83,801	\$0	\$136,062	\$12,369
<u>Department of Behavioral Health and Developmental Services (DBHDS)</u>						
Intellectual Disability (ID) Waiver						
Prevocational						
Services	850	\$4,479,869	\$4,479,869	\$0	\$8,959,738	\$10,541
Supported						
Employment*	775	\$4,393,048	\$4,393,048	\$0	\$8,786,097	\$11,337
Day Support Waiver						
Prevocational						
Services	66	\$332,299	\$332,299	\$0	\$664,598	\$10,070
Supported						
Employment*	28	\$149,536	\$149,536	\$0	\$299,072	\$10,681

*Supported Employment Services include individual and enclave models.

Sources: Department of Medical Assistance Services and Department of Behavioral Health and Developmental Services, respectively.

F. Monitoring and Evaluation of Employment Services

Department of Rehabilitative Services (DRS) Vocational Rehabilitation Program: The Commissioner of DRS is responsible for oversight of the agency's vocational rehabilitation

program and for ensuring compliance with both federal (34 CFR 361.1, *et seq.*) and state (22 VAC 30-20-10 to 200) regulations. Specific federal performance *Standards and Indicators* (34 CFR 361.80-89) have been established by the national **Rehabilitation Services Administration (RSA)**.

DRS is required to submit a number of monitoring and evaluation reports to RSA. Quarterly RSA “113 Reports” include the number of applicants, number determined eligible for services, number on waiting lists under the Order of Selection, number and types of case closures, and other data. The annual RSA “911 Report” contains raw, detailed demographic data on the number and type of vocational rehabilitation case closures, and the RSA “A2 Report” describes budget expenditures for different services.

Section 107 Monitoring and Technical Assistance Reviews are conducted by the RSA to ascertain whether the DRS vocational rehabilitation program meets its federal goals and objectives. If DRS is found to be noncompliant with RSA *Standards and Indicators*, its vocational rehabilitation program must develop and implement a *Performance Improvement Plan* consistent with RSA recommendations for improvement. RSA’s last Section 107 review occurred in 2009. Currently, DRS is under a *Performance Improvement Plan* due to the results of the federal fiscal year (FFY) 2009 *Standards and Indicators*.

The DRS state agency *Strategic Plan* includes agency goals, objectives, and performance measures. Annual evaluations of vocational rehabilitation counselors are based, in part, on individual objectives tied to these performance measures. If individual objectives are not met, appropriate corrective actions occur. In addition, case audit reviews of sample cases are conducted to ensure that appropriate policies and procedures are being followed and that high-quality services are being provided.

DRS also conducts an annual survey of its clients to determine their level of satisfaction with the services they received. In FFY 2009, the overall satisfaction rate for rehabilitated and non-rehabilitated service recipients was 81 percent, and 90 percent of service recipients continue to have a fairly strong belief that DRS staff treat them well. Additionally, 84 percent agreed that they would tell a friend to go to DRS for services, and 63 percent indicated that they would definitely come back to DRS if they needed additional help.

The DRS **Office of Technology and Employment Support Services** is responsible for the department’s specialty programs and works within the Field Rehabilitation Services Division to ensure the overall quality and effectiveness of service delivery. Further oversight information on individual DRS vocational rehabilitation services follows.

The specialty vocational rehabilitation counselors who provide services for clients through the **Serious Mental Illness Program** are directly supervised by the manager of their respective field offices and also receive indirect and programmatic supervision from the Program Specialist for Serious Mental Illness. To monitor service quality and effectiveness, the Program Specialist makes regular site visits to the local Community Services Boards (CSBs) that

participate in this program, and compiles statistical summaries of the employment outcomes and expenditures for case services. In addition, statewide meetings are convened several times a year to strengthen programming and to enhance consistency of services offered across the state. Similar quality control procedures apply to the **Substance Abuse Program**.

As above, the Program Specialist for the DRS **Deaf and Hard of Hearing Program** is responsible for the quality and effectiveness of its services, and in general, oversight practices are the same as for other DRS specialty programs. The Program Specialist also holds periodic community meetings to obtain direct feedback from service recipients, and program staff participate in quarterly meetings to receive ongoing training and to address service issues to enhance service delivery to this population.

Standard oversight practices apply to the DRS **Temporary Assistance for Needy Families (TANF) Program** as well. Program Specialists use site-monitoring visits to provide technical assistance, training, and other guidance to the staff of the collaborating local social services departments. The Department of Social Services (DSS) conducts onsite audits of these local departments to monitor their fiscal management of TANF funds.

DRS maintains formal vendor agreements with Employment Services Organizations (ESOs) that outline specific expectations and standards for **Supported Employment Services**. In addition, ESOs must be accredited by the national **Commission on Accreditation of Rehabilitation Facilities (CARF)**. Program accreditation must be reviewed and renewed by CARF every three years. When applicable, ESO vendor agreements also include specific standards for the provision of **Extended Employment Services** and **Long-Term Employment Support Services**. These programs are further monitored through a quality assurance review developed by DRS in cooperation with the **DRS Employment Services Organizations Advisory Council**.

Work Incentive Specialist Advocates (WISAs) are trained and certified by DRS using funds from the Medicaid Infrastructure Grant. Once qualified, WISAs apply to provide work incentives services for vocational rehabilitation customers as DRS vendors. WISAs must abide by DRS standards for such providers and must agree to accept the agency's fees for work incentives services.

Vocational training programs at the **Woodrow Wilson Rehabilitation Center (WWRC)** are accredited by the **Accrediting Commission of the Council on Occupational Education**, which conducts Accreditation Team site visits every six years. In addition to the typical DRS oversight mechanisms described above, WWRC distributes an annual report to the general public and provides annual outcome data to its accrediting organization, the state Department of Planning and Budget, and the state Workforce Investment Board.

WWRC also collects satisfaction information from sponsors who refer individuals for its employment services. A computer-based survey is sent out to each sponsor after case closures for clients receiving vocational rehabilitation, rehabilitation counseling, and life skills transition

services. Questions cover the usefulness of vocational evaluation recommendations, overall case management satisfaction, and the timeliness of reports. Additional consumer satisfaction surveys and focus groups of service recipients provide WWRC with their comments and suggestions for improvements.

Department for the Blind and Vision Impaired (DBVI) Vocational Rehabilitation Program: Federal **Rehabilitation Services Administration (RSA)** reporting, monitoring, performance evaluation, and corrective processes for DBVI's vocational rehabilitation programs are equivalent to those for DRS, and DBVI's Commissioner is responsible for oversight of the agency and its compliance with federal regulations (34 CFR 361.1 *et seq.*) and the *Code of Virginia* (Title 51.5, Chapter 12). RSA performance *Standards and Indicators* (34 CFR 361-80-89) also apply.

DBVI's most recent RSA *Section 107 Monitoring and Technical Assistance Review* occurred in 2009. RSA's report, available at www.rsa.ed.gov, has just been received, and DBVI's response is pending. The review found that DBVI met or exceeded required performance levels for compliance with the *Standards and Indicators*.

As was reported above for DRS, the DBVI state agency *Strategic Plan* includes its goals, objectives, and performance measures, and annual evaluations of its vocational rehabilitation counselors are based, in part, on individual objectives tied to its measures. Local supervisors monitor case activities by individual DBVI staff members, and if individual objectives are not met, appropriate corrective actions occur.

At the state level, the DBVI Vocational Rehabilitation Director is responsible for direct monitoring of all agency programs. DBVI's headquarters reviews case work by regional offices annually and conducts telephone and mail surveys to determine recipients' satisfaction with services received. All service recipients have the opportunity to participate in these surveys, and feedback is shared with appropriate staff to improve and enhance services. The same oversight practices apply to the **Virginia Rehabilitation Center for the Blind and Vision Impaired (VRCBVI)** in Richmond.

During state fiscal year (SFY) 2010, 329 customers completed their DBVI vocational rehabilitation program. Of these, 120 (36 percent) responded to the satisfaction survey, 54 (45 percent) of the respondents successfully reached their goals, and 66 (55 percent) did not. No problems with service providers or vendors were reported by 113 respondents (94 percent), while 7 (6 percent) indicated that problems were experienced.

Virginia Workforce Network: Oversight of the **Virginia Employment Commission's (VEC)** federally funded programs is the responsibility of the **U.S. Department of Labor's Employment Training Administration (ETA)**. Each program has its own negotiated and prescribed performance measures, and VEC is required to provide quarterly reports on outcomes. As noted in previous sections of this chapter, VEC reporting does not segregate data on its **Job Seeker and Employer Services** programs for individuals with and without disabilities.

At the state level, as required by the national *Workforce Investment Act* (WIA), the **Virginia Workforce Council (VWC)** assists the Governor in developing a five-year strategic plan detailing how the requirements of this statute will be met and how special populations will be served. VWC membership includes representatives from organized labor, the business community, the **Virginia Community College System (VCCS)**, local governments, and the General Assembly, as well as the Secretaries of Commerce and Trade, Education, and Health and Human Resources (HHR). There is no requirement for VWC membership to include people with disabilities; however, the Secretary of HHR represents the Department of Rehabilitative Services (DRS), the Department for the Blind and Vision Impaired (DBVI), and the Department of the Deaf and Hard of Hearing (DDHH), which are members of that secretariat.

As the state's WIA administrative agency, VCCS ensures that the Commonwealth complies with all applicable federal and state laws and regulations. Fifteen local **Workforce Investment Boards (WIBs)**, each serving a designated area, works with the VWC and VCCS to guide operations of the state's One-Stop Workforce Centers. Community representation varies between WIBs, based on local needs and services, but typically includes area employers, educational institutions, labor unions, economic development agencies, One-Stop partners including DRS and DBVI, and other community-based organizations. The local WIBs provide a forum to ensure that workforce training and employment initiatives meet local economic development and business needs. VCCS conducts annual reviews of WIB activities, the delivery of services by the One-Stops and youth programs, and the management of WIA funds.

To ensure that hard-to-serve populations, including people with disabilities, are served, the VWC's **One-Stop Committee** is responsible for reviewing and proposing changes to the certification process for the One-Stops, developing a certification and credentialing course for their staffs, strengthening their overall accessibility survey process, and finding ways to increase the number of General Educational Development (GED) certificates acquired by One-Stop customers in the pursuit of their employment goals. There are approximately 35 comprehensive One-Stops in Virginia. Some need to be certified for the first time, and others need to be recertified.

The VWC requires that One-Stops be physically and programmatically accessible to be certified, and its One-Stop Committee has discussed changes to strengthen the certification process that will increase the frequency of accessibility surveys conducted by DRS and the other Disability Services Agencies and include participation in the process by individuals with disabilities. DRS, in partnership with the Disability Program Navigator initiative and other interested agencies and organizations, will be instrumental in writing an up-to-date accessibility policy and protocol to be used as part of the One-Stop certification process. VCCS is in the process of hiring a One-Stop Services Coordinator whose responsibilities will include a lead role in certifying One-Stops, and DRS will collaborate closely with that Coordinator on accessibility certification standards.

The WIA also requires that the WIBs negotiate an annual agreement with the state on individual performance measures covering services for adults, minors, and dislocated workers.

Two customer satisfaction measures are based on the results of surveys asking quarterly samples of employers and individuals exiting employment programs about the services received. VCCS reports this information is reported to the U.S. Department of Labor, but it could not be used for this assessment because all programs are aggregated by WIB, not by service. In addition, the survey methodology generates a single score that does not translate into a typical customer satisfaction score and the number of survey respondents is so small that it does not accurately represent all One-Stop customers.

Work Incentive Programs: The federal **Social Security Administration (SSA)** is responsible for oversight of the **Ticket to Work** and **Work Incentives Planning and Assistance (WIPA) Program**. WIPA providers must apply for funds annually and submit quarterly program and semiannual financial reports to SSA, which also conducts periodic site visits and onsite audits. The details of these processes are too lengthy and complex to include in this assessment, and the SSA should be contacted directly for additional monitoring and evaluation information.

A member of the **Department of Medical Assistance Services' (DMAS) Program Operations Division** is responsible for monitoring **MEDICAID WORKS** enrollment and working with local departments of social services, when necessary, to assist with enrollment and eligibility issues. This staff member also serves as a resource for both the Work Incentive Specialist Advocates (WISA) authorized by the Department of Rehabilitative Services (DRS) and the Community Work Incentive Coordinators at SSA's designated WIPA Projects in Virginia. DMAS monitors new enrollment and cancellation reports and contacts all new enrollees, soon after their enrollment and periodically thereafter, to welcome them to the program and request information about their employment. In applying for MEDICAID WORKS, enrollees agree to keep DMAS informed of where they are employed, what their jobs are, their hours worked, and their incomes. DMAS uses this information to report monthly on the total number of enrollees, how many are self-employed, their age and hourly wage ranges, the average number of hours worked per week, and the number of enrollees in each of the five local department of social services regions.

Home and Community Based Services (HCBS) Waivers: The **Department of Medical Assistance Services (DMAS)** is required to ensure the health, safety, and welfare of all individuals served by HCBS Waivers and to ensure that providers comply with all federal and state regulations. As previously noted, it directly administers the **Individual and Family Developmental Disability (DD) Waiver**, while the **Department of Behavioral Health and Developmental Services (DBHDS)** administers and provides additional oversight for the **Intellectual Disability (ID) Waiver** and **Day Support Waiver**. Information on monitoring and evaluation of these waivers is included in the Medicaid chapter of this assessment.

G. Employment Services Sources Referenced in This Chapter

Links to websites and online documents reflect their Internet addresses in March 2011. Some documents retrieved and utilized do not have a date of publication.

Websites:

Code of Virginia:

<http://leg1.state.va.us>

U.S. Department of Labor:

Bureau of Labor Statistics:

www.bls.gov

Labor Force Statistics from the Current Population Survey,
Frequently Asked Questions About Disability Data:
www.bls.gov/cps/cpsdisability_faq.htm

Employment and Training Administration, Disability Program Navigator Initiative:
www.doleta.gov/disability/

U.S. Social Security Administration:

Ticket to Work:

www.yourtickettowork.com

Employment Network Directory:

www.yourtickettowork.com/endir?action=state&state=VA&Find=Find

The Work Site:

www.ssa.gov/work

Work Incentives Planning and Assistance Projects:

<http://www.socialsecurity.gov/work/WIPA.html>

vaACCSES (Virginia Association of Community Rehabilitation Programs):

www.vaaccses.org

Virginia Commonwealth University

Autism Spectrum Career Links:

www.vcu-autism.org

Rehabilitation Research & Training Center on Workplace Supports and Job Retention:

www.worksupports.com

Virginia Community College System:

www.vccs.edu

Virginia Department for the Blind and Vision Impaired:

www.vdbvi.org

Virginia Rehabilitation Center for the Blind and Vision Impaired:

www.vrcbvi.org

Virginia Department of Behavioral Health and Developmental Services:

www.dbhds.virginia.gov

Virginia Department of Medical Assistance Services:

www.dmas.virginia.gov

Virginia Department of Rehabilitative Services:

www.vadrs.org

School to Work Transition Services:

www.vadrs.org/transitionservices.htm

Woodrow Wilson Rehabilitation Center:

<http://wwrc.virginia.gov>

Your Path to Work:

www.vadrs.org/howvrworks.htm

Virginia Department of Social Services:

Local Departments of Social Services:

www.dss.virginia.gov/localagency

Virginia Employment Commission:

www.vec.virginia.gov

Virginia Workforce Network:

<http://myfuture.vccs.edu/WorkforceServices/VirginiaWorkforceNetwork/tabid/693/Default.aspx>

WorkWORLD™:

www.workworld.org/wwwwebhelp/va_medicaid_works_overview.htm

Documents:

Rehabilitation Research & Training Center on Disability Statistics and Demographics, Hunter College at CUNY. *Annual Disability Statistics Compendium 2010*. Retrieved from www.DisabilityCompendium.org.

United States Bureau of Labor Statistics. (August 25, 2010). *Persons with a Disability: Labor Force Characteristics News Release*. Retrieved from: www.bls.gov/news.release/archives/disabl_08252010.htm.

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vaACCSES (Virginia Association of Community Rehabilitation Programs). *Project WIT—Work Incentives Training for Successful Employment: A Day to Day User’s Guide*.

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Virginia Community College System. *Job and Career Assistance: Quick Reference Guides*. Retrieved from: <http://myfuture.vccs.edu/Default.aspx?tabid=789>.

Virginia Department for the Blind and Vision Impaired. (September 2010). *Agency Strategic Plan, 2008-2010*. Retrieved from: www.vdbvi.org/StrategicPlan.htm.

Virginia Department for the Blind and Vision Impaired. *Rehabilitation Services Administration Annual Review FY 2009*. Retrieved from: www.rsa.ed.gov/my_data.cfm?form_id=107&mode=view&grant_award_id=18878.

Virginia Department of Behavioral Health & Developmental Services. (June 25, 2010). *Creating Opportunities: A Plan for Advancing Community-Focused Services in Virginia*. Retrieved from: www.dbhds.virginia.gov/OPD-default.htm.

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V. Medicaid

A. Introduction

Medicaid is a publicly funded health insurance program authorized by Title XIX of the federal *Social Security Act* (42 USC 1396 *et seq.*) and administered by the states. It uses federal and state matching funds to provide medical and related insurance coverage for Americans with low income and other targeted populations, including individuals who are elderly or have disabilities and meet state eligibility requirements. For many individuals with disabilities or with low incomes, Medicaid is an essential resource and support for accessing health and long-term care supports. According to the 2010 Kaiser Family Foundation report, *Medicaid: A Primer*, individuals with disabilities are less likely to have private insurance than the general population, and an estimated 20 percent of non-elderly adults with a chronic disability living in the community are covered by Medicaid.

The federal **Centers for Medicare and Medicaid Services (CMS)** require states to cover certain services under Medicaid. States may also opt to cover additional services; however, federal regulations require that all services covered by a state under Medicaid, whether mandatory or optional, must be available statewide in the same amount, duration, and scope to everyone eligible for benefits and that eligible individuals must be able to choose their own providers for those services. Each state must submit a **Medicaid State Plan** to CMS for approval that describes its available mandatory and optional services. When indicated, states may submit Medicaid State Plan Amendments to CMS, requesting changes to their plans, at the end of each quarter of the calendar year.

Federal Medicaid regulations give states significant flexibility in designing their service systems by allowing them to apply for waivers of one or more of the CMS program requirements for uniform amount, duration, and scope of services in order to provide community service alternatives to institutionalization. **Medicaid Home and Community Based Services (HCBS) Waivers** for specific subpopulations of individuals identified as needing particular services are an example. For a waiver to be approved, the state's Medicaid agency, such as the **Virginia Department of Medical Assistance Services (DMAS)**, must assure CMS that the annual cost to provide community-based services is no more than the cost of comparable care in an appropriate institution, which varies by waiver. Federal regulations also allow states to determine whether to base this assurance on individual cost or average aggregate cost. Virginia uses aggregate cost methodology for its Medicaid HCBS Waivers.

The Virginia Joint Legislative Audit and Review Commission (JLARC) has noted that Medicaid is the second largest expenditure in Virginia's budget. Total Medicaid expenditures grew from \$4.8 billion in state fiscal year (SFY) 2009 to \$6.5 billion in SFY 2010, with much of the increase funded by temporarily enhanced federal matching funds discussed further in the cost and payment section of this chapter. Over the next 20 years, rising medical costs, the growing

elderly population, broadened eligibility criteria included federal health care reform legislation passed in 2010, and other recent initiatives to increase or improve access to publicly funded health care and long-term supports are expected to result in further substantial increases in both Medicaid enrollment and costs for Virginia.

DMAS received a \$1 million, four-year “Maximizing Enrollment for Kids: Making Medicaid and CHIP Work” grant from the Robert Wood Johnson Foundation in February 2009 to increase enrollment and retention of eligible children in public health insurance programs. DMAS is using these funds to improve systems, policies, and procedures; measure the impact of these changes; and thereby increase program effectiveness and efficiency. Under the direction of the National Academy for State Health Policy, each of the eight states receiving one of these grants will receive technical assistance with data collection and analysis to measure progress, a formal assessment of current enrolment and retention systems, and tailored assistance to develop and implement system improvement plans.

In March 2010, the U.S. Congress approved major health care reform legislation, the *Patient Protection and Affordable Care Act* (42 USC 18001). Although it will not be fully implemented until 2014, its expansion of Medicaid eligibility to all adults under age 65 with incomes at or below 133 percent of the federal poverty level is expected to have a significant impact on costs. In Virginia, this change is expected add 270,000 to 425,000 new Medicaid enrollees at an additional cost of \$1.5 billion between 2017 and 2022.

Soon after its passage, the Commonwealth filed a lawsuit challenging the constitutionality of federal health care reform. The following May, recognizing that legal issues could take several years to resolve, Virginia’s Secretary of Health and Human Resources announced a statewide **Virginia Health Reform Initiative** to not only prepare for potential implementation of federal health care reform, but also develop innovative health care practices that could improve access to services, disease prevention, workforce availability, service quality, and cost effectiveness. The *Report of the Virginia Health Reform Initiative Advisory Council* (www.hhr.virginia.gov/Initiatives/HealthReform) submitted to the Governor was released on December 20, 2010. Additional coverage of this initiative and its report appears in the Health chapter of this assessment; however, some of its key recommendations related to Medicaid include:

- Funding and implementation of the Virginia Gateway project which would create an automated application and eligibility system across Health and Human Services agencies;
- Convening multiple stakeholders to identify, pilot-test, and disseminate effective models of service delivery and payment reform;
- Piloting the use and payment of telemedicine in underserved areas of the state that would include application of a payer claims data base; and
- Exploring cost-sharing opportunities for the current and future expanded Medicaid population.

The 2011 Virginia General Assembly approved a number of budget items that addressed Health Reform Initiative recommendations and affected Medicaid funding or services relevant to individuals with disabilities. For example, to improve health systems, the legislature approved a Medicaid program that uses 100 percent federal funds to make incentive payments to eligible professionals and hospitals that adopt electronic health records technology. The Department of Medical Assistance Services (DMAS) will administer this program at an estimated cost of \$250 million dollars spread over six years beginning in state fiscal year (SFY) 2012.

The legislature also approved two major proposals from the Governor that will enhance community services. To reduce the waiting list for Medicaid Home and Community Based Services (HCBS) Intellectual Disability (ID) Waivers, it approved \$9.8 million of General Funds for SFY 2012 that will provide waivers for 275 additional individuals. Another \$30 million was approved for the Behavioral Health and Developmental Services Trust Fund that must be used to provide community-based services, including new Medicaid waivers for individuals transitioning from the state's training centers.

In addition, the 2011 General Assembly passed a number of budget amendments, some of which reduced the impact of cuts to Medicaid waiver services proposed by the Governor. Approved budget amendments included the following:

- Agency and consumer-directed personal care hours under the Elderly or Disabled with Consumer Direction (EDCD) Waiver and HIV/AIDS Waiver were capped at 56 hours per week, not to exceed 2,920 hours per year, effective in SFY 2012. The amendment requires, however, that DMAS provide for individual exceptions to this limit "using criteria based on dependency in activities of daily living, level of care, and taking into account the risk of institutionalization if additional hours are not provided." (Budget Item 297, #8c)
- General funds were restored in SFY 2012 to reduce the planned decrease in rates paid to providers of waiver services to one percent rather than five percent. (Budget Item 297, #12c)
- Respite care service hours for the EDCCD, HIV/AIDS, ID, and Individual and Family Developmental Disability (DD) Waivers, which had been limited to 720 hours per year were reduced to 480 hours per year, effective July 1, 2011, rather than 240 hours per year as had been proposed. This change was also applied to respite care hours under the Children's Mental Health Demonstration Grant, and the respite authorization period was changed from calendar year to state fiscal year. The limit applies to agency-directed services, consumer-directed services, or any combination of the two, and any unused hours from one year may not be carried over to the next year. (Budget Item 297, #14c)
- Funding was added beginning in SFY 2012 to support 150 additional DD Waivers. (Budget Item 297, #16c)

Two additional budget amendments will have potentially far-reaching impact on Medicaid State Plan and HCBS Waiver services:

- DMAS and the Department of Behavioral Health and Developmental Services (DBHDS) were tasked with examining ways to improve existing or develop new Medicaid HCBS Waivers for individuals with intellectual or developmental disabilities that would “increase efficiency and cost effectiveness, enable more individuals to be served, strengthen the delivery of person-centered supports, enable individuals with high medical needs and/or high behavioral support needs to remain in the community setting of their choice, and provide viable community alternatives to institutional placement.” These two agencies, in collaboration with appropriate stakeholders and national experts, must report recommendations to the General Assembly by October 1, 2011. (Budget Item 295.1, #1c)
- Setting the stage for eventual expansion of care coordination (managed care) for Medicaid services, DMAS was tasked with seeking necessary waivers or authorizations from the U.S. Centers for Medicare and Medicaid (CMS) to expand care coordination “to all geographic areas, populations, and services” under programs administered by DMAS. To accomplish this, DMAS will involve various stakeholders to develop and implement care coordination projects, which shall include monitoring of service “utilization, quality of care, outcomes, costs, and cost savings.”

In addition, the amendment requires DBHDS to work with stakeholders to develop a “blueprint” for a care coordination model for behavioral health services that includes details on funding, populations served, types of services provided, and a timeframe for project implementation and education of clients and providers. The blueprint must adhere to 18 specific principles of care coordination, and as specifically required by the amendment, targeted case management must remain the responsibility of local Community Services Boards (CSBs).

This amendment also delayed expansion of the state’s Medicaid managed care program, Medallion II, into the western and southwestern areas of the Commonwealth. The care coordination expansion plan must be completed for implementation in July 2012, and DMAS must report progress on this initiative to the General Assembly each year on the first day of November. (Budget Item 297, #21c)

Federal regulations and guidelines for Medicaid are too detailed and complex to cover them fully in this assessment, and the remainder of this chapter will provide only an overview of their implementation in Virginia. For more information, the Kaiser Family Foundation (www.kff.org) is a reliable, user-friendly source of basic data on individuals served, costs, eligibility, and covered services for Medicaid and the other federally established public insurance programs, as well as further details on federal health care reform.

B. Eligibility for Medicaid

Federal Medicaid regulations regarding eligibility, give states the option of using the Social Security Administration's (SSA) Supplemental Security Income (SSI) definition of "disability" or a more restrictive definition. Virginia uses the SSI definition but has very strict eligibility requirements regarding income and other factors. As a result, the Commonwealth's eligibility criteria for Medicaid are among the strictest in the nation, and while the rate of growth for expenditures in Virginia is comparable to that for the rest of the nation, its absolute level of Medicaid expenditures has been, and is, low in comparison to other states.

Populations with low incomes for whom Virginia's Medicaid program covers medical and medically related services include adults with dependent children, children from birth to age 19 and adults with disabilities, non-disabled dependent children up to age 21, the elderly age 65 and older, certain Medicare recipients, and pregnant women. While the Virginia **Department of Medical Assistance Services (DMAS)** is the designated state administrative agency for Medicaid and sets the guidelines for accessing services, local social services departments affiliated with the Virginia **Department of Social Services (DSS)** serve as the "gateways" for Medicaid coverage. Applications can be obtained from those local social services departments or online (www.dss.virginia.gov/benefit/medical_assistance/index.cgi). The completed application, signed by the adult or by the parent or guardian of a child needing assistance, is returned to the local department of social services where the individual lives, which then determines eligibility for Medicaid benefits.

To be eligible for Medicaid, an individual must be a legal resident of the Commonwealth and provide documentation of residence, identity, citizenship, and income. In some cases, they must also supply information on other resources and assets. If the applicant is not a U.S. citizen, but otherwise meets eligibility criteria, he or she must provide documents verifying immigration status and date of entry into the country. Information on acceptable documents can be obtained from the local social services department where the individual lives, DSS, or the DMAS website.

Children and youth may be eligible for one of two Virginia Medicaid programs. The state's basic plan, named **FAMIS Plus** but typically referred to just as Medicaid, covers children and youth in families with no or very low income. The **Family Access to Medical Insurance Security (FAMIS)** plan covers children and youth in families that earn too much to qualify for Medicaid (FAMIS Plus) but do not have private insurance. Children and youth under age 21 enrolled in Medicaid (FAMIS Plus) are also eligible for services under the **Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)** program, which requires that their doctor document an existing or emerging physical, behavioral, developmental, or mental impairment or problem that requires treatment to correct it or keep it from getting worse. If their doctor is unable to provide the needed services, they may be referred to specialty care, and certain of these services, such as intensive in-home services, therapeutic day treatment, and therapeutic behavioral services, have more extensive eligibility criteria.

To be eligible for full Medicaid (FAMIS Plus) coverage, gross income (total income before deductions and taxes are taken out) and resources (assets) must fall within required limits specified as percentages of the federal poverty level, an index that is adjusted over time. These income and resource limits vary among Medicaid's covered populations; however, individuals and families with incomes of 133 to 200 percent of the federal poverty level are generally covered. In determining resources, the amount of a person's or family's bills and debts is not considered, but in some instances, such as for individuals who are "medically needy," consideration may be given to the impact on a family of exceptionally high medical bills (counted as "spend-down") which work like an insurance deductible.

Children and youth from birth to age 19 with disabilities may qualify for Medicaid (FAMIS Plus) even if their family income exceeds income limits, since parental income and other financial resources are not considered in determining the child's eligibility. When a member of a married couple requires long-term care under Medicaid, special eligibility rules called spousal impoverishment protections are applied to determine resources and income that can be kept by the other spouse. Under the **MEDICAID WORKS** program, individuals who have a disability and who work or are about to start a job may earn more than for standard eligibility and retain more in savings or resources while continuing to receive Medicaid coverage. Additional information on MEDICAID WORKS can be found in the Employment chapter of this assessment, and because all of these income eligibility criteria are complex, it is recommended that individuals contact their local social services department for clarifications.

To receive services under Virginia's **Medicaid Home and Community Based Services (HCBS) Waivers**, an individual must meet both the general and waiver-specific eligibility criteria described below, meet long-term care criteria through a formal clinical assessment, and undergo an assessment of financial need. Financial and nonfinancial criteria for each waiver are covered below. Information on the screening process and accessing services is discussed in later sections of this chapter. Currently, the state has seven approved HCBS Waivers:

- Alzheimer's Assisted Living (AAL) Waiver (or simply, the Alzheimer's Waiver),
- Day Support Waiver,
- Elderly or Disabled with Consumer Direction (EDCD) Waiver,
- HIV/AIDS Waiver,
- Intellectual Disability (ID) Waiver (formerly Mental Retardation Waiver),
- Individual and Family Developmental Disability (DD) Waiver, and
- Technology Assisted (Tech) Waiver.

To be eligible for any of these HCBS Waivers, an adult's total income is limited to no more than 300 percent of the Supplemental Security Income (SSI) benefit limit (\$2,022 per month in 2010), and the adult may have not more than \$2,000 in resources. Parental income and resources are not considered in determining eligibility for minor children. Individuals with income in excess of 100 percent of the SSI benefit limit may be responsible for "patient pay" to

their provider as their share of the cost of care. This copayment is based upon the individual's gross income after subtracting a personal maintenance allowance, an allowance for a spouse or dependent children, and a deduction for medical expenses that are not covered by Medicaid or other third party insurance and remain the liability of the individual to pay. Eligibility requirements for the EDCD, Tech, and HIV/AIDS Waivers allow for a "spend-down" of resources related to income and out-of-pocket expenditures, and individuals eligible for the HIV/AIDS Waiver are allowed to keep more fiscal resources to cover work-related expenses.

To be eligible for the **Alzheimer's Assisted Living (AAL) Waiver**, Virginia's newest, state regulations (12 VAC 30-120-610) require that an individual:

- Be elderly or disabled as defined by Section 1614 of the federal *Social Security Act*,
- Meet the level of care for nursing facility placement,
- Have a diagnosis of Alzheimer's disease or a related dementia by a licensed clinical psychologist or licensed physician, and
- Both receive an Auxiliary Grant and reside in or be seeking admission into an assisted-living facility licensed as a special care unit by the Virginia Department of Social Services (DSS).

Individuals diagnosed with an intellectual disability as defined by the American Association for Intellectual and Developmental Disabilities or a serious mental illness as defined in federal regulations (42 CFR 483.102[b]) are not eligible for the Alzheimer's Waiver.

The **Day Support Waiver**, implemented in July 2005, is limited to individuals currently on either the urgent or non-urgent waiting lists for the ID Waiver. A person receiving services under the Day Support Waiver may remain on the ID Waiver waiting list until a "slot" becomes available and is assigned to him or her. The current annual state budget allocates funding for a maximum of 300 Day Support Waiver slots.

Individuals may receive services through the **Elderly or Disabled with Consumer Direction (EDCD) Waiver** while on the waiting list for an ID or DD Waiver. To be eligible for the EDCD Waiver, they must be age 65 or older or, regardless of age, have a disability, and they must meet criteria for nursing facility level of services.

To be eligible for the **HIV/AIDS Waiver**, an individual must be diagnosed by a physician as having the human immunodeficiency virus (HIV), be symptomatic of or diagnosed with acquired immune deficiency syndrome (AIDS), and additionally have symptoms which would require care in a nursing facility or acute care hospital.

Eligibility for the **Intellectual Disability (ID) Waiver** requires a formal assessment by a licensed professional resulting in a diagnosis of intellectual disability or, for a child younger than age six, a determination that the child is at developmental risk. The individual also must require the level of care provided by an intermediate care facility for persons with mental retardation

(ICF-MR). Eligibility determination requires a formal, standardized assessment of the person's current level of cognitive and general functioning, as well as identification of current, relevant medical information. The individual or family must also declare their choice for community-based services rather than institutional (ICF-MR) care.

Because the need for ID Waiver slots exceeds annual state budget allocations, additional criteria are used to prioritize who receives one. Waiting lists are maintained through a partnership between the **Department of Behavioral Health and Developmental Services (DBHDS)** and the local **Community Services Boards (CSBs)** that provide screening and assessment of individuals for the ID Waiver. Based on urgency of need criteria established by DBHDS, each CSB assigns individuals to one of three waiting list categories: urgent, non-urgent, or local planning list. Individuals on the non-urgent waiting list are served only after all individuals on the urgent list have been served, and in effect, they are unlikely to receive an ID Waiver slot unless personal circumstances change significantly for them to meet urgent list criteria. Individuals on the planning list generally qualify for the ID Waiver but do not meet the requirement of being willing to accept services within 30 days. That list is used administratively for future CSB service planning and is not part of the official waiting list.

For placement on the ID Waiver urgent waiting list, an individual must meet the following criteria in addition to the basic waiver requirements.

- The individual meets at least one of the six criteria below:
 - Both primary caregivers are 55 years of age or older or, if there is one primary caregiver, the primary caregiver is age 55 or older;
 - The individual is living with a primary caregiver who is providing the service voluntarily and without pay and who indicates that he or she can no longer continue to do so;
 - There is a clear risk of abuse, neglect, or exploitation;
 - The primary caregiver has a chronic or long-term physical or psychiatric condition significantly limiting his or her ability to provide care;
 - The individual is “aging out” of a publicly funded residential facility or otherwise in danger of becoming homeless (exclusive of youth who are graduating high school); or
 - The individual with ID lives with the primary caregiver, and there is a risk to the health or safety of the individual, primary caregiver, or other resident in the home because either:
 - The individual's behaviors present a risk to himself or others that cannot be effectively managed by the primary caregiver even with supports arranged for or provided by a CSB, or
 - The individual's physical (such as lifting or bathing) or medical needs cannot be managed by the primary caregiver even with supports arranged for or provided by the CSB.

- The individual needs services within 30 days.
- The individual with ID, his or her spouse, or the parent of a minor child with ID will accept the requested service, if offered.

In 2009, following its review of Virginia's ID Waiver renewal application, the U.S. Centers for Medicare and Medicaid (CMS) requested that the state standardize its process for assigning waiver slots. In response, DBHDS partnered with the Virginia Association of Community Services Boards (VACSB) and The Arc of Virginia to develop a uniform, statewide process that became effective in January 2010. Details of this process appear in the later section of this chapter on access to and delivery of services.

Individuals residing in community ICFs-MR or nursing facilities (nursing homes) are not eligible for placement on the urgent waiting list based on the rationale that their health, safety, and welfare needs are being met in the institution. In recent years, however, ID waiver slots have been specifically allotted to residents of DBHDS' training centers and other slots have been made available to nursing home residents with ID through the Money Follows the Person (MFP) initiative to facilitate their transition from institutional to community services.

The **Individual and Family Developmental Disability (DD) Waiver** is targeted to individuals age six years or older who do not have a diagnosis of intellectual disabilities but do have another "related condition." As with the ID Waiver, diagnostic and functional criteria are considered in determining DD waiver eligibility, individuals must meet the level of care criteria for services in an ICF-MR, and individuals or their families must choose community-based services rather than institutional (ICF-MR) care. Children with developmental disabilities who are under the age of six can receive services under the ID Waiver; however, they must transition to the DD Waiver by age six. If they do not transition in a timely manner, they are placed on the DD waiver waiting list.

Unlike the ID Waiver, the DD Waiver has a single, statewide waiting list, and with the exception noted below, slots are assigned from that list on a first-come, first-served basis. Individuals on the list are categorized into one of two "levels" based on the anticipated costs of their service plans, with Level 1 estimated to cost less than \$25,000 per year and Level 2 to cost more than \$25,000 per year. These categories do not generally impact the slot assignment process; however, ten percent of Level 1 DD Waiver slots are designated as "emergency" slots without consideration of the length of time on the waiting list. To be eligible for one of these slots, at least one of four emergency criteria must be met:

- The primary caregiver has a serious illness, has been hospitalized, or has died;
- The individual has behaviors that present a risk to personal or public safety;
- The local social services department has determined that the person has been abused and is in need of immediate waiver services; or
- Home care for the individual presents an extreme physical, emotional, or financial burden that the family or caregiver can no longer bear without the assistance of the waiver.

Individuals needing both a medical device to compensate for the loss of a vital body function and substantial, ongoing skilled nursing care may be eligible for the **Technology Assisted (Tech) Waiver**. Eligibility criteria and screening processes for youth up to age 18 and adults is different, and screening processes are covered along with those for other HCBS Waivers in the next section of this chapter. Eligible adults must be dependent for at least part of the day on a ventilator or meet complex tracheotomy criteria, and the cost effectiveness of technology services is compared to specialized care in a nursing facility. Children and youth younger than 21 must be dependent for at least part of the day on a ventilator, meet complex tracheotomy criteria, or have a daily dependence on some other device-based respiratory or nutritional support, and the cost comparison for their services is to a long-stay hospital.

C. Access to and Delivery of Medicaid-Covered Services

Once an individual is found to be eligible for Medicaid, the **Department of Medical Assistance Services (DMAS)** mails them a plastic medical assistance card, which is used like any other insurance card. When more than one individual in a family is found eligible for Medicaid, each receives his or her own card. Services under the **Medicaid State Plan** are delivered through a broad array of public providers and private nonprofit or for-profit providers who accept Medicaid as a reimbursement and agree to meet specific guidelines on the scope and documentation of their services. DMAS provides individuals covered by Medicaid with a list of these providers, and extensive information on how to access services is available in its *Guide for Long-Term Care Services in Virginia* (http://dmasva.dmas.virginia.gov/Content_atchs/ltc/ltc-guide_srvcs.pdf).

As mentioned previously, information on the **MEDICAID WORKS** program for individuals with disabilities who are or want to be employed is available in the Employment chapter of this assessment or can be obtained from local social services departments or Work Incentive Planning and Assistance (WIPA) programs. The latter are also described in detail in the Employment chapter.

Shared and specific eligibility criteria for Virginia's **Medicaid Home and Community Based Service (HCBS) Waivers** were detailed in the previous section of this chapter. This section provides additional details on their screening processes and on how services are accessed once eligibility has been determined. Although there are common elements shared by some of the waivers, the complete screening and access process for each is unique. Access to each waiver requires an individualized assessment by professionals who use a standardized evaluation tool, and as reflected through the results of those tools, eligible individuals must meet the level of care for facility placement. Both the assessment tool and alternative placement vary by waiver, and alternative placement criteria were identified in the eligibility section. For all of the waivers, additional documentation of the formal assessments by appropriate professionals of an individual's medical and physical conditions or cognitive functioning is required. There is no charge for eligibility screening for any of the state's HCBS Waivers, and screening

responsibilities for the various state and local agencies and the assessment tools involved are described below.

- Local departments of health and social services complete screenings for the Elderly or Disabled with Consumer Direction (EDCD) Waiver and HIV/AIDS Waiver for youth and adults. They also screen the elderly for the Alzheimer's Assisted Living (AAL) Waiver and adults only for the Technology Assisted (Tech) Waiver. The **Uniform Assessment Instrument (UAI)**, which assesses social, physical, health, and other functional criteria, is used in all of these screenings.
- The state Department of Medical Assistance Services (DMAS) screens children and youth under age 18 for the Technology Assisted (Tech) Waiver using a waiver-specific scoring tool. It also does a follow-up review of an adult's private insurance coverage for adults seeking that waiver.
- Community Services Boards (CSBs) screen youth and adults for the Intellectual Disability (ID) Waiver and the Day Support Waiver using the **Level of Functioning (LOF) Survey**.
- Local health clinics screen adults and Virginia Department of Health (VDH) Child Development Clinics screen youth for the Individual and Family Developmental Disability (DD) Waiver, also using the Level of Functioning (LOF) Survey.

Prior to 2009, in addition to the UAI and LOF Survey assessments, completion of a supplemental screening by local CSBs was often required for individuals with mental illness, intellectual disabilities, or related conditions seeking access to any of the Medicaid HCBS waivers. This screening frequently created delays in accessing the EDCCD, HIV/AIDS, and Tech Waivers, and on January 1, 2009, DMAS eliminated this requirement for applicants seeking those waivers.

There is no **waiting list** for the EDCCD, HIV/AIDS, Tech, and Alzheimer's Waivers, and while there is no separate list for the Day Support Waiver, it is limited to individuals already on either the urgent or non-urgent waiting list for the ID Waiver. Waiting lists, however, would occur for the Alzheimer's and Day Support Waivers if their number of applicants exceeded the maximum number of slots set for those waivers by state regulations (200 and 300, respectively). For youth and adults with intellectual or other developmental disabilities seeking ID and DD Waivers, state funding has not kept pace with need, resulting in large and ever-growing waiting lists.

Individuals on either the urgent or non-urgent waiting list for the ID Waiver gain access to the Day Support Waiver according to their "date of need," defined as the date on which they were determined to be eligible for the ID Waiver. Individuals must be willing to begin services immediately or no later than 30 days from the date of request. Once an individual has been placed on the statewide waiting list, the date of need will never change. According to available data, 287 persons were served through the Day Support Waiver in state fiscal year (SFY) 2010, an increase of 8.3 percent over SFY 2007 when 265 were served.

Once an individual has been determined by the appropriate agency to be eligible for a HCBS Waiver, a list is offered by that agency from which the individual or his or her family can choose service providers. Delivery and management of services vary by waiver. Case management, a Medicaid State Plan service, is available to individuals determined eligible for the ID, Day Support, DD, Tech, and HIV/AIDS waivers as soon as soon as that determination has been made, regardless of whether they have obtained an actual waiver slot. Individuals receiving services through the EDCD waiver do not have access to case management unless they are elderly (subject to geographic and time limitations) or are on the ID or DD Waiver waiting list. As a result, depending on the level of coordination by their providers, those individuals may have more than one **plan of care**.

Under the ID and Day Support Waivers, a case manager or support coordinator from the local CSB or its contracted entity works with an individual, and his or her family if appropriate, to create an **Individual Services Plan (ISP)** detailing the preferred supports to meet that individual's needs and select their providers. Under the ID and Day Support Waivers, if the individual so chooses, the CSB or its contracted entity may also provide those supports.

Unlike the ID Waiver, the DD Waiver's **Consumer Service Plan (CSP)** and related forms are standardized statewide, and the providers selected by an individual, or his or her family if appropriate, for case management or support coordination services and for other direct services cannot be the same organization. Otherwise, the CSP is similar to the ISP and plans of care for other HCBS Waivers, describing the services to be provided and including all supporting documentation.

The table below shows the number of persons served under the **Intellectual Disability (ID) Waiver** in recent years. These counts and those on subsequent tables do not include individuals who had requested waivers but were still awaiting determination of eligibility or individuals who might be eligible for waiver services but are not aware of them and have not applied for them. The data, therefore, may underestimate total demand and need.

NUMBER OF INDIVIDUALS SERVED UNDER THE ID WAIVER

State Fiscal Year (SFY)	Number Served	Change	Percent
2005	6,421	-----	-----
2007	6,850	429	6.7%
2010	7,975	1,125	16.4%

Source: Department of Behavioral Health and Developmental Services, Office of Developmental Services.

As the next table shows, while the number of available slots funded by the General Assembly has increased, growth in the number of individuals on the waiting list prior to receiving a slot and services has been much greater and remains a major concern. Despite an increase in the number of slots by 6.7 percent from 2005 to 2007 and by 16.4 percent from 2007 to 2010, the total number on waiting lists increased by 39.4 percent from 2007 to 2010, with that

increase driven significantly more by growth of the urgent list (45.8 percent) than the non-urgent list (32.3 percent).

NUMBER OF INDIVIDUALS ON ID WAIVER WAITING LISTS

Waiting List	06/30/2007*	07/01/2010**	Change	Percent
Urgent	2,017	2,946	929	46.1%
Non-Urgent	1,855	2,455	600	32.3%
Total	3,872	5,401	1,529	39.5%

Sources: *Department of Medical Assistance Services. **Department of Behavioral Health and Developmental Services, Office of Developmental Services.

Moreover, as the table below illustrates, the typical amount of time that individuals spend on ID Waiver waiting lists also continues to grow and be of concern. The length of time reflects the period from placement on the waiting list until the start of actual access to waiver services. Its duration is influenced by the availability of funding for new waiver slots, an individual's priority status, and changes in the number of persons needing services each year. Please note that the "points in time" for year-to-year comparisons in the data below and the total number on the waiting lists indicated by the following and previous tables are not consistent due to limitations of the state's data systems.

LENGTH OF TIME ON ID WAIVER WAITING LISTS

Length of Time	Number as of: 12/18/2007	07/01/2010	Change
Less than 1 year	1,009	508	-50%
1 year	757	1,089	44%
2 years	646	981	52%
3 years	460	759	65%
4 years	384	503	31%
5 years	152	454	199%
6 years	112	315	181%
7 years or longer	138	535	288%
Total	3,658	5,144	41%

Source: Department of Behavioral Health and Developmental Services, Office of Developmental Services.

As previously noted, a uniform process for assigning ID Waiver slots by local **Community Services Boards (CSBs)**, with two tiers of review, was implemented statewide in January 2010. Priority is given to individuals found eligible for the urgent waiting list, and information gathered by an individual's support coordinator prior to assignment of an ID Waiver slot include:

- Relevant, current medical information;
- Level of Functioning Survey;

- A recent psychological evaluation or, if under age 6 years, a standardized developmental assessment;
- Documentation that the individual or his or her family or caregiver, as appropriate, chose ID Waiver services over ICF-MR placement; and
- A completed **Critical Needs Summary**, which must be updated at least annually and whenever “critical needs” of the individual change. This form generates a priority needs score that is maintained in a CSB client database.

The first tier of review in the assignment process commences whenever a CSB has any waiver slots available. If five or fewer are available, the CSB identifies the ten individuals on its urgent waiting list who have the highest Critical Needs Summary scores. If more than five slots are available, twice as many individuals as the number of available slots are identified. When two or more individuals have identical scores and are at the cut-off number, all are included in the second tier of review.

A **Waiver Slot Assignment Committee** conducts the second tier of review as soon as possible after a slot becomes available. Committee members, selected by the local CSB, typically include various members of that CSB’s staff as well as staff from neighboring CSBs, family members of individuals already receiving ID Waiver services, legislators, staff from local social services departments and Department of Rehabilitative Services’ field offices, and other stakeholders. A support coordinator who serves on the committee cannot vote when one of the individuals whom he or she supports is being considered for a slot, and no one with a direct or indirect interest in the outcome of the review can be on the committee.

Prior to the second tier review meeting, written summaries prepared by the support coordinators for each of the individuals being considered for an ID Waiver slot are submitted to the members of the assignment committee. Each summary must include the following:

- The individual’s or family’s current need for services including health and safety issues, behavioral challenges, and community integration or social isolation issues;
- Services currently received by the individual;
- Natural supports available to the individual including primary caregiver information and other family, friend, or community supports present;
- Descriptions of any other conditions for urgency; and
- Description of the waiver services determined necessary to relieve the urgency.

After discussing this information, each committee member assigns a numeric score to each of the categories listed above for each individual being considered, and a total of each committee member’s categorical scores is compiled for each of those individuals. An average of all committee members’ total scores for each individual being considered is then calculated, and the individuals with the highest average scores receive the available ID Waiver slots. Further

information on this review and assignment process is available at www.dbhds.virginia.gov/ODS-MRWaiver.htm.

As described earlier, allocation of **Individual and Family Developmental Disability (DD) Waiver** slots is done statewide on a first-come, first-served basis. The **Virginia Department of Medical Assistance Services (DMAS)** maintains a chronological waiting list based on the date on which an individual was determined to be eligible for the DD Waiver. When funds are allocated for new slots or a current slot becomes available, the individual on the list with the earliest date is assigned the slot. A slot may become vacant because an individual moves out of state, is no longer qualified for the waiver, obtains services through other funding arrangements, or dies.

The following tables, similar to those above for the ID Waiver, depict the number of unduplicated individuals who received services under the DD Waiver or were on the DD Waiver waiting list as of June 30, the end of the state fiscal year (SFY), for selected years between 2005 and 2010. The total and percentage changes for that entire period are also indicated. Waiting list data by level of need was not available for the most recent years.

NUMBER OF INDIVIDUALS SERVED UNDER THE DD WAIVER

<u>State Fiscal Year (SFY)</u>	<u>Number Served</u>	<u>Change</u>	<u>Percent</u>
2005	338	----	----
2007	408	----	----
2009	584	----	----
2010	582	244	72.2%

Source: Department of Medical Assistance Services.

NUMBER OF INDIVIDUALS ON DD WAIVER WAITING LIST

<u>State Fiscal Year</u>	<u>2005</u>	<u>2007</u>	<u>2009*</u>	<u>2010*</u>	<u>Change</u>	<u>Percent</u>
Level 1 Needs	161	246	----	----	----	----
Level 2 Needs	123	248	----	----	----	----
Total	284	594	757	993	709	250%

* The distribution between Level 1 and Level 2 Needs was not available for SFYs 2009 and 2010.

Source: Department of Medical Assistance Services, as of June 30 of each year.

In comparison, recipients of services under the DD Waiver (582) in 2010 were less than a tenth (7.3 percent) of the number served through the ID Waiver (7,975), and even more so than for ID Waivers, growth in the number of DD Waivers (72.2 percent) has been far exceeded by the increase (250%) in the number of individuals waiting for a waiver. A critical factor contributing to this difference has been the relative lack of new appropriations by the General Assembly for DD Waiver slots compared to ID Waiver slots. This is in part due to the much larger number of individuals on the ID Waiver waiting list and a very strong and cohesive advocacy lobby for ID Waiver slots. In addition, until July 1, 2009, there was no single lead

state agency designated for DD Waiver services planning, which made their inclusion in state budget proposals more difficult. A sizeable proportion of individuals with developmental disabilities other than intellectual disabilities have also applied for and received services under the EDCD Waiver that has no capacity limit.

Both the Governor and the legislature have expressed concern that the waiting lists for the ID and DD Waivers continue to increase at a fast pace and have taken action to address this concern. In 2009, the General Assembly expressed its intent to eliminate these waiting lists and tasked the Governor with developing a formal plan to do so (*Code of Virginia*, 32.1-323.2). The administration's response, developed by the Departments of Medical Assistance Services (DMAS) and Behavioral Health and Developmental Services (DBHDS) in late 2009, reported that the waiting lists were growing by approximately 699 individuals per year for the ID Waiver and 154 for the DD Waiver. To eliminate both waiting lists by the end of state fiscal year (SFY) 2020, the legislature would need to fund 1,100 new ID Waiver slots and 220 new DD Waiver slots annually between SFY 2011 and 2020.

As the report to the legislature noted and is show below, the actual number of new slots funded annually for the past eight fiscal years has been well below this level, averaging just 360 per year for the ID Waiver and 38 per year for the DD Waiver. This includes both slots originally legislatively planned plus an additional 110 ID Waiver and 15 DD Waiver slots designated each year for the Money Follows the Person (MFP) demonstration project in 2009 and 2010.

ANNUAL NUMBER OF NEW ID AND DD WAIVER SLOTS ALLOCATED

State Fiscal Year (SFY)	New ID Waiver Slots	New DD Waiver Slots
2003	150	0
2004	175	0
2005	860	105
2006	0	0
2007	303	65
2008	468	100
2009	710	15
2010	210	15
Total	2,876	300

Source: Department of Medical Assistance Services and Department of Behavioral Health and Developmental Services' 2009 *Plan for Elimination of Waiting Lists under Medicaid: ID and DD Waivers*.

The national economic recession led to a dramatic decline in state revenues beginning in 2008, and as a result, the 2009 General Assembly eliminated funding for 200 new ID Waiver slots planned for state fiscal year (SFY) 2010. In 2010, the legislature approved funding for 250 new ID Waiver slots over the next biennium; however, this funding was contingent upon extension of **Federal Medical Assistance Percentage (FMAP) Funding**, with restoration at the

discretion of the Governor. After much debate, the U.S. Congress approved the *Education Jobs and Medicaid Assistance Act* that extended FMAP Funding for six months in federal fiscal year (FFY) 2011, but at a rate of only 3.2 percent from January through March and 1.2 percent from April through June. This extension provided Virginia with \$262.6 million, significantly less than the \$430 million that the General Assembly had expected. Nevertheless, the 250 new ID Waiver slots were restored and allocated by DBHDS in 2010. The following year, the General Assembly approved funding for 275 additional ID Waiver slots and 150 DD Waiver slots for SFY 2012.

As funding for the other Medicaid Home and Community Based Services (HCBS) Waivers, especially the ID and DD Waivers, has remained flat, more and more individuals with ID and DD have turned to the **Elderly or Disabled with Consumer Direction (EDCD) Waiver** as a means of receiving needed services. As reflected in the table below, the unduplicated number of individuals served under the EDCD Waiver grew by 9,698 from state fiscal years (SFY) 2005 to 2010, a dramatic 81.5 percent increase with most of that growth occurring toward the end of that period. From SFY 2007 to 2010, the number grew by 7,634 individuals, 64.1 percent.

NUMBER OF INDIVIDUALS SERVED UNDER THE EDCD WAIVER

State Fiscal Year (SFY)	Number Served	Change	Percent
2005	11,901	-----	-----
2006	12,588	687	5.8%
2007	13,965	1,377	10.9%
2008	16,159	2,194	15.7%
2009	18,640	2,481	15.4%
2010	21,599	2,959	15.9%

Source: Department of Medical Assistance Services.

The number of individuals receiving services through the remaining three Medicaid HCBS Waivers is relatively small compared to those described above. The following table shows data on the number of unduplicated individuals served under the **Alzheimer's Assisted Living (AAL), Technology Assisted (Tech), and HIV/AIDS Waivers** for selected state fiscal years (SFY) between 2005 and 2010 as well as the amount of change for the entire period.

NUMBER OF INDIVIDUALS UNDER THE TECH, AAL, AND HIV/AIDS WAIVERS

State Fiscal Years	2005	2007	2009	2010	Change	Percent
AAL Waiver*	-----	18	32	62	44	204%
HIV/AIDS Waiver	213	384	61	60	-153	-71.8%
Tech Waiver	363	384	400	405	42	11.6%

* The AAL Waiver was not available until SFY 2006.

Source: Department of Medical Assistance Services.

In contrast to the slow but steady growth in the number of individuals served by the AAL and Tech Waivers between 2005 and 2010, the number served under the HIV/AIDS Waiver decreased significantly, by 71.8 percent. This is generally believed to be due to improvements in medications and treatments that enable individuals with HIV or AIDS to live without the need for nursing facility level of care, decreasing the number of individuals who continue to meet that criterion for this waiver.

While the number of individuals receiving services through the AAL Waiver more than tripled from 2007 to 2010, initial participation since its inception in 2005 has been slow and total participation remains low compared to most of the other waivers. This has largely been due to need for outreach to potential providers and delays in the provider enrollment process.

According to Department of Medical Assistance Services (DMAS), potential providers expressed concern over additional licensing expectations set by the Department of Social Services (DSS), and new regulations have been proposed to improve consistency with waiver requirements in the areas of licensed care professionals, synchronization of medication distribution by registered medication aides, the number of activity hours provided, and the education and certification of direct care staff. In anticipation of the adoption of these proposed licensing regulation changes, provider enrollment has increased significantly.

DMAS has also undertaken targeted marketing efforts to identify potential service providers and recipients for the AAL Waiver. In 2010, the most recent year prior to this assessment, it made presentations at two statewide conferences for operators of assisted-living facilities and conducted multiple trainings for preadmission screeners to clarify admissions and screening issues and to promote the use of the AAL Waiver for long-term care.

As demonstrated by the slow growth for the AAL Waiver, an important factor in accessing all Medicaid supports is having a sufficient local **service capacity** of enrolled providers to meet eligible individuals' needs. Unfortunately, state data limitations currently make it difficult to determine the total number and capacity of Medicaid HCBS Waiver service providers by region. In 2010, the Department of Medical Assistance Services (DMAS) implemented a new provider database, which is used nationally, but as of this assessment, DMAS has not yet been able to generate provider data based on the type of waiver covering a service.

There are two basic ways that individuals can access services under Medicaid HCBS Waivers, **consumer-directed services** which are described in greater detail below and **agency-directed services** available from a variety of governmental, nonprofit, and for-profit organizations. In addition, specific requirements such as professional licenses for staff members or agency licensure by the Virginia Department of Behavioral Health and Developmental Services (DBHDS) or other state agencies may be required for some service providers, and to be enrolled as an in-state provider for the Commonwealth, a service provider must be located no more than 50 miles outside of the state's borders. Case managers or service coordinators can provide information about local service providers. Lists are also available from DMAS, and its

website has a provider search feature at http://dmasva.dmas.virginia.gov/Content_pgs/search-home.aspx.

Implementation of consumer-directed services under several of the Medicaid HCBS Waivers has improved the availability of certain services and enabled individuals, and their families or guardians where appropriate, to retain freedom of choice and control of the direct services that they receive. The concept and practice of consumer-direction is an important component of effective community integration of persons with disabilities and refers to situations in which the individual with the disability who is receiving service, the “consumer,” has responsibility for deciding how and when services will be provided and who will provide them. Both the ID and DD Waivers include consumer-direction for personal and respite care for children and adults and companion services for adults. The HIV/AIDS, EDCD, and Day Support Waivers also cover consumer-directed personal assistance and respite services. Consumer-directed services are currently not available under the Alzheimer’s or Tech Waivers.

As the recipient of consumer-directed services, an individual with a disability (or his or her designated representative) is the **employer of record** with the federal Internal Revenue Service (IRS) and functions as manager of his or her own staff. If desired by the service recipient, facilitators may provide lists of attendants, companion aides, and respite workers and teach individuals with disabilities how to place help-wanted advertisements. DMAS contracts with a fiscal agent that handles payment of these providers on behalf of the individual receiving their services. Several reader-friendly guides developed by self-advocates through Virginia’s **Systems Transformation Grant** to help individuals implement consumer-directed services are available at www.vcu.edu/partnership/cdservices/pcprb.htm.

A **Medicaid appeal process** is authorized under both federal (CFR 431 *et seq.*) and state (12 VAC 30-110-10 through 370) regulations when an individual is denied eligibility for Medicaid insurance coverage or for a type of service. Individuals must be notified in writing of an “adverse action” at least ten business days prior to a denial or cancellation of coverage or services. The individual then has 30 days from that notification to file a written appeal request with the **Department of Medical Assistance Services (DMAS) Appeals Division**. “Good cause” exceptions to the 30 day time limit are permissible only in special circumstances such as a personal emergency. Written appeal requests may be in the form of a letter, an e-mail, or a completed appeal request form available from local social services departments, the DMAS website (www.dmas.virginia.gov), or by calling 804-371-8488. Telephone and verbal requests for appeal are not accepted, and a copy of the adverse action notification should be included with the written request or request form.

If the appeal is filed before the effective date of the adverse action, Medicaid-covered services may continue during the appeal process if the provider is so willing and the individual so requests. If services are continued or reinstated due to the appeal, the provider can neither terminate nor reduce services until the hearing officer has rendered a decision; however, if the adverse action is later upheld by the hearing officer, the individual will be required to reimburse

DMAS for the cost of the services received during that time period. Because of this, some individuals may choose not to continue services during the appeal process.

At any point during the process, an individual may choose to withdraw his or her appeal, and DMAS may also act to approve or reinstate coverage based on new information or a new evaluation. If the latter occurs, DMAS must notify the individual and the Appeals Division of its decision in writing, and if the Appeals Division determines that there has been an “administrative resolution” of the issue, it can decide to formally close the appeal rather than proceed with a hearing.

If an appeal is not administratively resolved, the Appeals Division reviews the appeal request and any new information provided, then determines whether to validate or to invalidate and dismiss the appeal. An appeal may be invalidated because, for example, it was filed late or it offered no new information. If the appeal is validated, the Appeals Division schedules a hearing and notifies the individual of its location, date, and time by mail two to three weeks in advance.

The neutral presiding officer at the hearing allows each side to present facts regarding the adverse action. The individual making the appeal can bring representatives or witnesses, submit new documents or evidence, examine agency documents, and raise questions. The hearing officer makes his or her decision based on questions of evidence, procedure, and law, and may sustain (support), reverse, or remand the denial of coverage or services. A remand requires DMAS to conduct an additional evaluation of the information or to provide new information. The hearing officer’s decision must be made within 90 days of the appeal request date. Both the individual requesting the appeal and DMAS receive a copy of the hearing officer’s decision, and if the individual disagrees with that decision, he or she may appeal to the Circuit Court.

DMAS statistics indicate that approximately 75 percent of all appeals that have hearings and full dispositions are sustained by their hearing officers. Over time, the number of appeals has grown from 2,106 in state fiscal year (SFY) 2005, of which 1,891 (89.8 percent) were validated, to 3,388 in SFY 2010, when 2,970 (87.8 percent) were validated. While the number of validated appeals increased by 1,079 (36.3 percent) during this period, the number of hearing officers statewide has remained constant at 11, and hearing officers have experienced a dramatic increase in workload from an average of 172 validated appeal requests each in SFY 2005 to 270 in SFY 2010.

D. Services Available Through Medicaid

In compliance with federal regulations, Virginia’s Medicaid program provides for the following **mandatory services** that must be covered for all who meet eligibility criteria:

- Inpatient and outpatient hospital services;
- Emergency hospital services;
- Rural health clinics and federally qualified health centers;

- Physician and nurse midwife services;
- Nursing facility services;
- Applicable durable medical equipment;
- Laboratory and x-ray services;
- Early and periodic screening, diagnosis, and treatment (EPSDT) services for children and adolescents under age 21;
- Home health services (nurses, aides); and
- Transportation services to receive covered services.

Of these, **early and periodic screening, diagnosis, and treatment (EPSDT)** is one of the most critical services for children and adolescents under age 21. EPSDT covers preventative and other health care services including well child examinations, assessments and screenings, immunizations, dental care, vision and hearing services, and “medically necessary” diagnostic and treatment services to correct or improve physical conditions, behavioral issues, and mental illness identified by assessments. Children eligible for EPSDT can receive all services determined to be medically necessary regardless of whether those services are covered under the Medicaid State Plan, and EPSDT is also available to children receiving services under a Medicaid Home and Community Based Services (HCBS) Waiver. Additional information on EPSDT services covered by Medicaid can be found in the Early Intervention chapter.

In addition to the aforementioned federally mandated services, the *Code of Virginia* (32.1 *et seq.*) authorizes the state’s Medicaid program to cover nineteen categories of **optional services** which include, but are not limited to:

- Prescription drugs,
- Rehabilitation services (occupational, physical, speech and related therapies),
- Home health services (physical therapy, occupational therapy, and speech/language pathology),
- Dental services for youth under age 21,
- Skilled nursing facility services for youth under age 21,
- Case management services,
- Some mental health and substance abuse services,
- Hospice, and
- Intermediate care facilities for persons with mental retardation (ICFs-MR) services.

Dental, orthodontics, and limited medically necessary oral surgery services for children are covered under Medicaid (FAMIS Plus) and Family Access to Medical Insurance Security

(FAMIS) by the combined program **Smiles for Children**. Details of this program for both service recipients and providers can be found at www.dmas.virginia.gov/dental-enrollees.htm.

Further information about Virginia's mandatory and optional Medicaid-covered services, their eligibility requirements, and types of approved providers is available in print and online from the Department of Medical Assistance Services (DMAS, www.dmas.virginia.gov).

The required mandatory and optional services that apply to basic Medicaid State Plan coverage are also available to all recipients of services under **Medicaid Home and Community Based Services (HCBS) Waivers**. Some services, however, are waiver specific, varying in amount and type between waivers, and the availability of any waiver or waiver service is dependent on, and therefore limited by, annual state appropriations made by the Virginia General Assembly. For example, as noted in the introduction to this chapter, the allowable hours for personal care and respite services for several of the waivers described below were reduced effective July 1, 2011, with potential exceptions based on emergency regulations to be developed by DMAS.

Transition services and coordination have recently been added to several of the HCBS Waivers, as noted below, to assist with moving individuals from institutions to the community under the **Money Follows the Person (MFP)** initiative. Transition services are defined (12 VAC 30-120-2010) as "set-up expenses for individuals who are transitioning from an institution or licensed or certified provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for his own living expenses." Under MFP, DMAS contracts with and trains local or regional providers who serve as transition coordinators that who support individuals and their families or caregivers, as appropriate, in planning and making arrangements associated with transitioning from an institution to the community. Additional information on the MFP initiative appears in the Community Supports chapter of this assessment.

For individuals eligible for Medicaid or both Medicaid and Medicare, the **Alzheimer's Assisted Living (AAL) Waiver** covers services in a safe, secure assisted-living environment. Covered services include assistance with daily living activities, housekeeping, and supervision, administration of medications, and therapeutic and recreational programming based on a person's needs and interests in a safe, secure environment. Nursing evaluations and Medicaid services such as medication, physician's visits, acute care hospitalizations, and certain therapies are also covered. Case management is not covered under this waiver. Services are paid for on a per diem basis, 365 days a year, with a maximum annual allowance of 14 days for home visits.

Services currently available under the **Day Support Waiver** include day support, prevocational services, and supported employment.

The **Elderly or Disabled with Consumer Direction (EDCD) Waiver** funds medication monitoring, agency- or consumer-directed personal care services, adult day health care, personal response systems, respite care, and transition services.

Services covered under the **HIV/AIDS Waiver** include case management, nutritional supplements, private day nursing, personal response systems, agency- or consumer-directed personal and respite care, and transition services. There is no patient pay requirement for services under this waiver.

The **Intellectual Disability (ID) Waiver** provides for assistive technology, attendant services, agency- or consumer-directed companion and respite services, crisis stabilization and supervision, day support, family and caregiver training, environmental modifications, in-home and congregate residential support, personal care services, personal emergency response systems, prevocational services, supported employment, skilled nursing, therapeutic consultation, and transition services.

Similar supports are covered by the **Individual and Family Developmental Disability (DD) Waiver** as for the ID Waiver; however, while ID Waiver funds can be used for supports either in a group residential setting or in an individual or family home, the DD Waiver only funds in-home supports.

The **Technology Assisted (Tech) Waiver** covers personal emergency response systems, durable medical equipment, and transition services for youth and adults as well as personal care services for adults only. Environmental modifications and assistive technology are covered, up to a maximum of \$5,000 a year for each category, but only if medically necessary and cost-effective. Respite care is limited to 360 hours per year. Private duty nursing services are also covered but are limited to 16 hours per day, with the exception that youth age 20 or younger may receive this service for 24 hours per day during their first 30 days of enrollment in the waiver.

E. Cost and Payment for Medicaid

Medicaid is jointly funded through federal and state tax revenues. Administrative costs are split equally between federal and state funds. Each state sets its own fiscal reimbursement rate for each covered service. A formula is used to determine the percentage of the federal payment for each service covered by a state, and the state is required to cover the remaining service cost, known as “state Medicaid match.” The federal portion, its “match,” varies annually but typically ranges between 50 and 83 percent among the states. For Virginia, the standard federal match is set at 50 percent; however, as noted in the introduction to this chapter, temporarily enhanced federal match of 61.59 percent through the *American Recovery and Reinvestment Act (ARRA)* reduced the Commonwealth’s state match to 38.41 percent for a portion of state fiscal year (SFY) 2009. This enhanced match continues through June 2011 and returns to equal shares of federal funds and state General Funds thereafter. Virginia also receives an increased federal match for individuals participating in the Money Follows the Person (MFP) initiative.

Under the *Code of Virginia* (32.1-325.2), Medicaid is the “**payer of last resort**”; that is, when an individual is covered both by third party private insurance and by Medicaid, the private insurer first must pay for any services covered under its policy. Medicaid also requires adults to contribute a small “copayment” toward the costs of certain medical services such as visits to an

outpatient hospital, clinic, or physician's office, home health visits, rehabilitation services, and inpatient hospitalization. The copayment can be made at the time of the service or billed to the service recipient by the provider. Medicaid Home and Community Based Services (HCBS) Waivers do not require copayment per service from participants for basic Medicaid State Plan services, but a waiver recipient may have a "patient pay" contribution for certain services based on amounts and sources of income. The Department of Social Services (DSS) assesses whether an individual receiving services under a HCBS Waiver is responsible for a patient pay.

The **Department of Medical Assistance Services (DMAS)** is responsible for making and tracking payments made under Medicaid and does so in one of two ways, as a fee-for-service based on specific reimbursement rates or through a managed care system. With fee-for-service, the service provider directly bills DMAS for a service received by a Medicaid client. Within managed care, DMAS operates two distinctly different programs. **Medallion**, administered by DMAS directly, is a primary care case management program in which the individual's primary care physician coordinates medically necessary care that includes referrals to specialists. **Medallion II**, administered through contracted managed care organizations (MCOs), is mandatory for many Medicaid (FAMIS Plus) individuals and is a fully capitated, risk-based program. MCOs provide most Medicaid-covered services for their enrollees in return for a fixed per capita monthly payment that covers a comprehensive set of services regardless of the amount or frequency of services used by each enrollee. For June 2010, DMAS reports that 484,801 individuals, 61.3 percent of its Medicaid clients, received services through managed care, an increase from 443,316 individuals, 59.8 percent, in June 2009.

Growth in the number of Medicaid enrollees, 49 percent from 2000 to 2010 according to DMAS' 2011 *Medicaid At-a-Glance* report, is a driving force behind the increase in Medicaid expenditures. Much of this growth can be attributed to general state population increases, especially among the elderly and those with disabilities. Other sources, however, indicate that most of the recent enrollment increase is directly related to the recession, both in Virginia and in other states. For example, *State Fiscal Conditions and Medicaid*, an issue brief by the Kaiser Family Foundation, reports that each increase of one percent in the national unemployment rate results in 1.1 million more individuals without private insurance coverage, one million more Medicaid enrollees, and a likely decline in state revenues of three to four percent.

While noting these and other factors, presentations to the General Assembly's fiscal committees in November 2010 recognized that much of this growth can be attributed to expanded enrollment of children and adults without disabilities. Enrollments for this population began to increase in state fiscal year (SFY) 2002, which featured program reforms and the beginning of outreach campaigns targeted at uninsured children, then sharply increased between SFY 2008 (two percent annual growth) and 2009 (eight percent annual growth). In comparison, there was a much smaller increase in enrollment growth for individuals categorized by Medicaid as elderly and as blind or disabled between those two years (two percent and 2.4 percent, respectively). This trend continued into SFY 2010 when there was an eight percent increase for adults and youth without disabilities versus three percent for those identified as elderly or as blind or disabled.

The following table comparing data for SFY 2007 and 2010 shows the number of Virginians enrollees by the four population categories tracked by Medicaid, their proportion of the total number of enrollees, and the proportion of total expenditures attributable to each category. It also reflects the recent proportionately larger growth in both number of enrollees who are children and adults without disabilities and the cost for their services described above.

COMPARISON OF MEDICAID ENROLLEES AND EXPENDITURES

Population Category	SFY 2007			SFY 2010		
	Number of Enrollees	% of All Enrollees	% of All Expenditures	Number of Enrollees	% of All Enrollees	% of All Expenditures
Elderly	81,541	9%	21%	80,016	8%	18%
Blind/Disabled	182,636	20%	47%	196,952	20%	47%
Children	487,929	55%	22%	563,379	56%	24%
Adults	142,180	16%	10%	164,814	16%	11%
Total	894,286	100%	100%	1,005,1661	100%	100%

Source: Department of Medical Assistance Services (DMAS).

While those categorized as elderly and blind or disabled comprised only 29 percent of enrollees in SFY 2007 and 28 percent in SFY 2010, expenditures attributed to those two populations made up 68 percent and 65 percent, respectively, of the total costs for those two years, indicating that those two groups have the highest per capita use and cost of services. In contrast, children and adults without disabilities comprised 71 percent of enrollees and accounted for only 32 percent of costs in SFY 2007, and they comprised 72 percent of enrollees and accounted for only 35 percent of costs in SFY 2010.

The legislative presentations further noted that Virginia's Medicaid costs have risen from approximately \$2.7 billion in SFY 2000 to \$6.5 billion in SFY 2010 (140 percent), even more rapidly than its enrollment (49 percent, as noted above), and that the reasons for this increase are numerous and complex. The table below compares expenditures over that period for several service categories.

COMPARISON OF VIRGINIA MEDICAID EXPENDITURES

(in millions of dollars, with percentages of total)

Service Category	SFY 2000		SFY 2010	
Acute Care	\$1,601.2	59%	\$3,382.5	53%
Nursing Facilities	470.9	17%	793.4	12%
Medicaid Waivers	256.6	9%	955.3	15%
MH/ID Facilities	251.6	9%	419.3	6%
MH/ID Community	73.4	3%	589.7	9%
Medicare Premiums & Other Payments	78.9	3%	\$408.6	6%
Total	\$2,732.6	100%	\$6,548.8	100%

Source: Massart, Susan E. (November 17, 2010). *Costs and Trends in the Virginia Medicaid Program*. Presentation to the House Appropriations Committee of the Virginia General Assembly. Richmond, Virginia.

Medicaid expenditures for acute care services include medical and dental outpatient services, durable medical equipment, inpatient hospital care, and prescription drugs. The expenditures in this category also more than doubled over the past ten years. Factors contributing to this growth were increases in enrollment of children and adults, inflation, policy decisions to increase rates, and use of higher cost services related to pregnancy, childbirth, and neonatal care.

Mental health (MH) and intellectual disability (ID) community services includes mental health outpatient services and supports for adults and youth, inpatient supports for youth, and case management by Community Services Boards for individuals with mental illness and intellectual disabilities. The amounts and proportions of expenditures for this category and for services under Medicaid HCBS Waivers both increased. In contrast, while expenditures grew dramatically for nursing facilities and MH/ID facilities, their proportion of total expenditures declined. This reflects increased enrollment for waiver services, expansion of waiver slots, and greater reliance on community care rather than institutions. Other factors included inflation and increased use of personal care services, especially consumer-directed care.

Despite the recent substantial growth in its Medicaid expenditures, Virginia still spends relatively less than other states. In its report *Virginia Compared to Other States*, the Joint Legislative Audit and Review Commission (JLARC) examined all of the state's Medicaid expenditures, including all medical assistance payments as well as state and local administrative costs but excluding payments under the Children's Health Insurance Program (CHIP), and determined that Virginia ranked near the bottom (47th) among the states in **per capita Medicaid expenditures** for federal fiscal years (FFY) 2007 and 2008. In FFY 2007, Virginia expended \$645 per capita (an increase of only \$26 from FFY 2005), compared to the national average of \$1,023. For FFY 2008, Virginia spent \$691 versus \$1,082 nationally.

Both in Virginia and nationally, individuals with disabilities rely on Medicaid to fund **long-term care services**. Virginia funds several broad categories of these services through Medicaid. The following table shows the relative proportions of these expenditures for state fiscal years (SFY) 2008 and 2010, including both state and federal funds, versus the total amount spent in the state for Medicaid long-term care services during those years.

DISTRIBUTION OF MEDICAID LONG-TERM CARE EXPENDITURES

<u>Long-Term Care Category</u>	<u>SFY 2008</u>	<u>SFY 2010</u>
Intermediate Care Facilities for Persons with Mental Retardation (MR)	14.5%	13.2%
Mental Health Facilities	3.2%	2.9%
Nursing Facilities	41.1%	38.1%
Home Health, Personal Care, and HCBS Waivers	41.2%	45.8%
<u>Total</u>	<u>100%</u>	<u>100%</u>

Source: Department of Medical Assistance Services (DMAS).

As the above table shows, Virginia's spending for institutional long-term care services has declined in recent years relative to spending for services in community settings, including **Medicaid Home and Community Based Services (HCBS) Waivers**. The next table details expenditures and funding sources for each of the state's HCBS Waivers during state fiscal year (SFY) 2009. Since providers have up to a year to file for reimbursements for services, more recent data on SFY 2010 was not available at the time of this assessment.

**SFY 2009 VIRGINIA EXPENDITURES FOR
MEDICAID HOME AND COMMUNITY BASED SERVICES (HCBS) WAIVERS**

Medicaid HCBS Waiver	Number Served^A	Waiver- Specific Costs^B	Acute Care Costs^C	Total Cost	State Funds^D	Federal Funds^D	Per Capita Cost^E
Alzheimer's Assisted							
Living (AAL)	32	\$477,316	\$17,060	\$494,376	\$211,148	\$283,228	\$15,485
Day Support	283	\$3,369,954	\$3,020,091	\$6,390,045	\$2,729,188	\$3,660,857	\$22,694
Developmental							
Disability (DD)	584	\$15,372,085	\$6,615,647	\$21,987,732	\$9,390,960	\$12,596,772	\$37,768
Elderly or Disabled with Consumer							
Direction (EDCD)	18,640	\$296,402,695	\$104,181,884	\$400,584,579	\$171,089,674	\$229,494,905	\$21,893
HIV/AIDS	61	\$872,354	\$860,996	\$1,733,319	\$740,301	\$993,018	\$28,650
Intellectual							
Disability (ID)	7,748	\$485,106,855	\$93,446,137	\$578,572,992	\$247,108,525	\$331,464,467	\$74,727
Technology							
Assisted (Tech)	400	\$30,391,914	\$21,234,973	\$51,626,887	\$22,049,843	\$29,577,044	\$129,200

- A. Total number of individuals receiving services under each waiver at any time in SFY 2009.
- B. Costs only for those services specifically provided under each waiver.
- C. Costs for Medicaid State Plan acute care medical services (doctor visits, X-rays, medications, etc.) and transportation, for which recipients of waiver services are also eligible, that were received by individuals under each waiver.
- D. Reduced state match at an annualized rate of 42.71% for SFY 2009 for both waiver-specific and acute care costs due to temporarily enhanced federal match at an annualized rate of 57.29% through the *American Recovery and Reinvestment Act* (ARRA). The enhanced federal match applied only for a portion of the year.
- E. As calculated by DMAS, the sum of per capita cost for waiver-specific services plus per capita cost for acute care services for each waiver. Since different numbers of individuals received waiver-specific and acute care services under each waiver, this is not the same as the total cost for both waiver-specific and acute care services divided by the total number of individuals served for each waiver. The latter calculation may be higher for some waivers and lower for others.

Source: Department of Medical Assistance Services (DMAS).

As can be clearly seen above, per capita costs for the seven waivers vary widely due to the differences in the scope and types of services covered. For example, per capita cost for the Tech Waiver is significantly higher because eligible individuals have more complex medical needs, such as dependence on a ventilator for at least part of the day, and rely on more expensive medical services. As noted earlier, while services are generally similar under the ID and DD waivers, the former covers supports provided both in-home and in group homes or other

congregate residential settings, and the latter is restricted to in-home supports which are typically less costly.

A more meaningful context for examining the costs of Medicaid HCBS Waivers is to compare the actual cost for serving individuals who are currently supported through waivers in community settings to the estimated cost of serving those individuals in their designated alternative institutional placements. These estimates, calculated by the Department of Medical Assistance Services (DMAS) for SFY 2009 using data for the same individuals counted in the table above, appears in the table below.

**COST ESTIMATES OF ALTERNATIVE PLACEMENTS
FOR INDIVIDUALS SERVED BY MEDICAID HCBS WAIVERS IN SFY 2009**

Alternative Placement Institution	Applicable Waivers	Estimated Number Served	Estimated Per Capita Cost
Nursing Home/Facility	Alzheimer's, EDCD, and HIV/AIDS	24,406	\$51,428
Intermediate Care Facility for Persons with Mental Retardation (ICF-MR)	Day Support and ID	1,897	\$168,532
Specialized Care Nursing Facility or Long-Stay Hospital	Tech	172	\$185,558

Source: Department of Medical Assistance Services (DMAS).

It must be emphasized that future Medicaid enrollment and costs are difficult to project since numerous variables are beyond the control of the Commonwealth and its Department of Medical Assistance Services (DMAS). The duration and full impact of the current recession is unknown, as are future shifts in Medicaid policy and regulations and the implications of federal health care reform, most notably the *Patient Protection and Affordable Care Act* mentioned briefly in this chapter's introduction and in more detail in this assessment's Health Care chapter. Other variables affecting Medicaid in Virginia will include growth in the elderly population, especially those with chronic health conditions; an increase in the number of individuals with disabilities, new requirements such as electronic medical records; and continuing increases in health care costs. Regarding the latter, a 2010 presentation by the Congressional Budget Office (CBO) to the Institute of Medicine, titled *Health Costs and the Federal Budget*, noted that per capita health care costs rose faster than per capita gross domestic product during the past decade and that rising costs per enrollee will have the most long-term impact on Medicaid spending.

F. Monitoring and Evaluation of Medicaid Expenditures

As administrator of the state's Medicaid program, the **Department of Medical Assistance Services (DMAS)** is responsible for ensuring that taxpayer funds are spent wisely and efficiently. To do so, it has established internal fiscal processes and an extensive "real time"

database for monitoring expenses and guaranteeing legal and regulatory compliance. It has also maintained a very lean administration, reducing administrative costs from 2.36 percent of expenditures in 1999 to 1.7 percent in 2009. In addition to improved administrative productivity, the DMAS emphasis on cost effectiveness has included initiatives such as:

- Cost-containment for pharmaceuticals,
- Fraud prevention,
- More effective data systems,
- An enhanced Help Line and expanded online and electronic systems for service pre-authorization and claims submission, and
- Expansion of managed care and integration of acute and long-term care.

The DMAS Commissioner is required to certify annually to the Virginia **Department of Accounts (DOA)** and **Auditor of Public Accounts (APA)** that the agency's internal control system has been maintained and evaluated, and both the DOA and APA conduct external reviews to ensure the integrity of all DMAS fiscal processes. As a part of its reviews, the APA develops an annual report on all of the state's Health and Human Resources agencies. In its January 2010 report, the most recent, the APA not only had no audit "findings" for DMAS, it gave an "unqualified opinion" on the agency's 2009 financial statements. In laymen's terms, this meant that the fiscal information was represented fairly in accordance with generally accepted accounting principles and was free from material misstatements.

As the state's Medicaid administrator, DMAS also approves, contracts, or otherwise arranges for other entities to conduct most screening, case management, service, and billing-related activities. While others may be the direct providers of these activities, DMAS remains ultimately responsible for ensuring that:

- The full scope of Medicaid services is available for covered individuals,
- An adequate supply of qualified providers has been enrolled in the program to meet their demand and offer them a choice of providers,
- Services paid for by Medicaid are of good quality and are added or changed as needed to protect recipients' health, safety, and welfare, and
- All providers operate in compliance with state and federal laws and regulations.

To comply with federal regulations, DMAS conducts periodic quality management reviews and evaluations of all programs and services paid for by the publicly funded insurance programs that it administers, including their utilization by both providers and recipients. This includes surveying service recipients and providers to determine the quality and responsiveness of those programs and services. Additional compliance reviews occur whenever it is indicated that providers are delivering services in excess of or outside of established norms and after receipt of complaints from agencies or individuals. Results of these quality assurance activities reported to the administration, legislative committees, federal oversight agencies, and the public

at-large by DMAS cover enrollment and expenditure trends, survey outcomes, and the programs' success in reaching appropriate participants, including people with disabilities. Many of those reports are cited throughout the chapters of this assessment.

DMAS uses a prior authorization process, program integrity activities, and audits of paid provider claims to ensure proper payments. Prior authorization determines that services are medically necessary before they are approved for reimbursement, and providers participating in Medicaid must ensure that requirements for services rendered are met in order to receive payment. Then before any payment is made, DMAS reviews eligibility of providers and ensures that the payment is for an eligible recipient, the appropriate service, and the correct amount.

Under their required Medicaid participation agreements, providers must make records and facilities available in response to reasonable requests for access from DMAS representatives, the Attorney General of Virginia and his or her authorized representatives, and authorized federal personnel or designees. When potential fraud by a provider is identified, DMAS refers the information to the state's **Medicaid Fraud Control Unit of the Office of the Attorney General (OAG)** for prosecution. Similarly, when fraud by a recipient is identified, the local Commonwealth Attorney is notified. The state Department of Social Services (DSS) and local social services departments are involved with investigation of potential recipient fraud as well. The OAG Medicaid Fraud Control Unit's report for state fiscal year (SFY) 2010 stated that the unit achieved 13 legal convictions and total recoveries of \$25,390,467 from criminal and civil investigations that year, and recoveries have averaged \$198,032,584 annually for the past three years.

The 2010 General Assembly (HJR 127) tasked the **Joint Legislative Audit and Review Commission (JLARC)** to study and report on the nature and extent of fraud, waste, abuse, and inefficiency in Virginia's Medicaid program and compare Virginia's activities to address these problems with those of other states. JLARC's Interim Report: *Fraud and Error in Virginia's Medicaid Program* (<http://jlarc.state.va.us/reports/Rpt404.pdf>) was released in December 2010 and identified the following most frequent types of improper Medicaid payments:

- Using incorrect medical codes,
- Failing to bill a third party such as Medicare,
- Billing for an item or service without adequate documentation,
- Billing for medically unnecessary services, and
- Billing for costs or services not reimbursable under Medicaid.

The interim report further notes that improper Medicaid payments in state fiscal year (SFY) 2009 totaled \$38.9 million, of which 52 percent (\$20,220,016) was attributable to fraud and the remainder to errors, mostly provider claim errors. For that year, DMAS avoided up to \$50.3 million in potentially fraudulent or incorrect claims by blocking improper claims before they were paid. While its report acknowledged the multiple methods already in use by DMAS, JLARC found that the case sample used by DMAS and DSS for Medicaid Eligibility Quality

Control (MEQC) reviews was not sufficiently large enough to ensure that provider reimbursement claims are valid. JLARC recommended that DMAS and DSS initiate a pilot project to better identify error rates in eligibility determination by local social services departments and report their findings by October 1, 2011.

The **Office of Licensure and Certification (OLC) of the Virginia Department of Health (VDH)** is responsible for licensing, monitoring, and managing compliance for a wide range of public and private health care facilities and service providers such as hospitals, outpatient clinics, nursing facilities, hospice programs, home care organizations, certain laboratories, and other testing facilities. OLC is also responsible for certification of managed care health insurance plans, and under Titles XVIII and XIX of the federal *Social Security Act*, it is the state's official certification agency for service providers eligible for reimbursement under Medicaid and Medicare. Specific certification, inspection, monitoring, and compliance requirements, set by federal regulation, vary by type of service. Details, as well as procedures for submitting and resolving service complaints, can be found at www.vdh.virginia.gov/olc, and information on OLC's quality assurance activities for direct services for people with disabilities can be found in the Community Supports and Institutional Services chapters of this assessment.

For Virginia's **Medicaid Home and Community Based Services (HCBS) Waivers**, DMAS conducts **Quality Management Reviews (QMRs)** to ensure the health, safety, and welfare of waiver service recipients and ensure compliance with federal and state regulations. Because of waiver differences, DMAS review processes are specific to each waiver. For waivers that cover case management or support coordination services, DMAS monitors whether individuals are eligible for waiver-specific services, whether those individuals have an appropriate Individualized Service Plan (ISP) based on a comprehensive, regular assessment of their needs, and whether services are being delivered, reviewed, and modified as required by their plans. It also reviews provider qualifications, checks whether services are consistent with billing limitations and documentation of need, and conducts annual level of care reviews. Following completion of a review, DMAS staff share findings with a provider in an "exit conference" that includes technical assistance and education. A written report of DMAS findings is also sent to the provider. Providers not in compliance may face a variety of sanctions including repayments to DMAS or termination of their provider agreements.

While DMAS is ultimately responsible for ensuring the health, safety, and welfare of Medicaid service recipients, regardless of whether it contracts out administration or management of those services, the **Department of Behavioral Health and Developmental Services (DBHDS)** is responsible for ensuring that its licensees comply with safety, quality, human rights, and other relevant policies and regulations. This includes additional oversight for the Day Support and Intellectual Disability (ID) Waivers administered by DBHDS. Staff members from its Office of Developmental Services periodically review ISPs for persons receiving services through those two waivers, whether those services are provided by local Community Services Boards (CSBs), other public providers, or private nonprofit or for-profit providers.

In addition, DBHDS Community Resource Consultants monitor the new two-tiered ID Waiver slot assignment process described earlier to ensure statewide consistency. Each time a CSB assigns available ID Waiver slots, it must send its assigned consultant a copy of the computer spreadsheet identifying the individuals to whom the slots were assigned and listing the Critical Needs Summary scores for all individuals on the CSB's urgent waiting list considered during each tier of the assignment process. The consultant then confirms that the correct individuals were considered by the Waiver Slot Assignment Committee and received the available slots. The consultants also provide periodic training and technical assistance for case managers and service providers as a part of their regular operations, at the request of a provider, or in response to problems identified by the DBHDS Office of Licensing or DMAS Quality Management Review staff.

Over the past two years, a major concern for DBHDS has been the need to develop a data system that will enable it to gather information on critical incidents in such a manner that it can be analyzed for patterns and trends. The results of this analysis would improve decision-making about changes in policies, monitoring, and training to enhance the department's overall performance and reporting to the federal Centers for Medicare and Medicaid (CMS).

G. Medicaid Sources Referenced in This Chapter

Links to websites and online documents reflect their Internet addresses in March 2011. Some documents retrieved and utilized do not have a date of publication.

Websites:

Code of Federal Regulations (CFR):

www.gpoaccess.gov/cfr/index.html

Kaiser Family Foundation:

www.kff.org

State Health Facts:

www.statehealthfacts.org

National Academy for State Health Policy:

www.nashp.org

Office of the Attorney General for Virginia:

www.vaag.com

Medicaid Fraud Control Unit:

www.vaag.com/consumer/medicaid_fraud/index.html

Office of the Inspector General for Behavioral Health and Developmental Services,
Commonwealth of Virginia:

www.oig.virginia.gov

OIG Reports – DBHDS Operated Facilities:

www.oig.virginia.gov/rpt-Facilities.htm

Office of the Secretary of Health and Human Services (SHHR), Commonwealth of Virginia:

www.hhr.virginia.gov

Health Reform Initiative:

www.hhr.virginia.gov/Initiatives/HealthReform

Systems Transformation initiatives:

www.hhr.virginia.gov/Initiatives/SystemsTransformation

Partnership for People with Disabilities, Virginia Commonwealth University:

Systems Transformation Grant Resource Bank:

www.vcu.edu/partnership/cdservices/pcprb.htm

Robert Wood Johnson Foundation, National Academy for State Health Policy:

Maximizing Enrollment for Kids:

www.maxenroll.org

U.S. Centers for Medicare and Medicaid (CMS):

www.cms.gov

Children's Health Insurance Program (CHIP):

www.cms.gov/home/chip.asp

Medicaid:

www.cms.gov/home/medicaid.asp

Virginia Department of Behavioral Health and Developmental Services (DBHDS):

www.dbhds.virginia.gov

Intellectual Disability (ID) Waiver Services:

www.dbhds.virginia.gov/ODS-MRWaiver.htm

Office of Developmental Services:

www.dbhds.virginia.gov/ODS-default.htm

Virginia Department of Health (VDH):

www.vdh.virginia.gov

Division of Long-Term Care:

www.vdh.virginia.gov/OLC/LongTermCare

Laws, Regulations & Guidelines:

www.vdh.virginia.gov/OLC/Laws/index.htm

Office of Licensure & Certification:

www.vdh.virginia.gov/olc

Virginia Department of Medical Assistance Services (DMAS):

www.dmas.virginia.gov

Appeals Division:

www.dmas.virginia.gov/app-home.htm

Long-Term Care & Waiver Services:

http://dmasva.dmas.virginia.gov/Content_pgs/ltc-home.aspx

Maternal and Child Health Programs:

http://dmasva.dmas.virginia.gov/Content_pgs/mch-home.aspx

Smiles for Children:

www.dmas.virginia.gov/dental-enrollees.htm

Virginia Department of Social Services (DSS):

www.dss.virginia.gov

About Medical Assistance Programs:

www.dss.virginia.gov/benefit/medical_assistance/index.cgi

FAQs About Medical Assistance:

www.dss.virginia.gov/files/division/bp/medical_assistance/Intro-page/faq/eligibility.pdf

Medicaid Forms/Processes:

www.dss.virginia.gov/benefit/medical_assistance/forms.cgi

Virginia General Assembly:

<http://legis.state.va.us/homepage.html>

Code of Virginia:

<http://leg1.state.va.us/cgi-bin/legp504.exe?000+cod+TOC>

State 2011 Budget:

<http://leg2.state.va.us/MoneyWeb.NSF/sb2011>

Virginia Administrative Code:

<http://leg1.state.va.us/cgi-bin/legp504.exe?000+men+SRR>

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VI. Community Supports

A. Introduction

The programs and services in this chapter, broadly referred to as “community supports,” enable individuals with disabilities and their families to determine for themselves where and how they will live and to be fully integrated into all facets of community life. Here, in Virginia, and nationally, expansion of community supports enables ever increasing numbers of individuals with disabilities who have varied levels of support needs to have homes in communities with or near their families rather than reside in institutions. This chapter will focus on publicly funded or operated programs across the Commonwealth that support and encourage self-determination and community integration for these individuals and their families.

Numerous state agencies fund, license, provide, or contract for services and supports that promote community inclusion and integration. Their sources of funds and the regulations governing their application impact eligibility for, access to, and availability of those services and supports. As a result, disability services are often designed to address the specific needs of one or more populations for which an agency or organization is funded, resulting in disability- or age-specific services. The number and diversity of public and private nonprofit and for-profit service providers across the state adds to this complexity, producing multiple points of entry and access, each with its own eligibility criteria.

A number of significant positive developments to improve comprehensive, integrated planning and service delivery for persons with developmental disabilities have occurred since the 2008 edition of this assessment, including the federally funded **Money Follows the Person (MFP) demonstration project** and the **Systems Transformation Grant (STG)**. Elements of these two statewide initiatives have facilitated transition of individuals with disabilities from institutional to community residential settings of their choice, supported the creation and expansion of the **No Wrong Door** online portal for services, fostered person-centered practices in regulations and clinical services, and improved quality assurance and monitoring of critical incidents. While the STG initiative is scheduled to conclude in September 2011, funding for MFP has been extended through federal fiscal year (FFY) 2016. Additional information about the impact of MFP appears later in Institutional Services chapter of this assessment.

In state fiscal year (SFY) 2009, a long-standing goal of disability advocates was achieved with the official designation of a lead state agency responsible for planning and coordination of services for individuals with autism spectrum disorders (ASD) and other developmental disabilities. The role of the existing Virginia Department of Mental Health, Mental Retardation and Substance Abuse Service (DMHMRSAS) was expanded, and its name was changed to the **Department of Behavioral Health and Developmental Services (DBHDS)**.

Concurrent with this development and with the needs of individuals with ASD receiving attention in the state and across the nation, the Virginia General Assembly directed the **Joint**

Legislative Audit and Review Commission (JLARC) to conduct a study on the availability and delivery of ASD services in the Commonwealth. Published in June 2009, its *Assessment of Services for Virginians with Autism Spectrum Disorders* (House Document 8, <http://jlarc.state.va.us/Reports/Rpt388.pdf>) covered numerous agencies and programs. Due to its new role with respect to developmental disability services, DBHDS was designated to take the lead in developing a response to the report's 31 recommendations.

In November 2010, with input from multiple agencies and stakeholders, DBHDS released an action plan detailing how the department and its partner agencies plan to address the system issues identified by JLARC and improve the system of care for individuals with ASD. Some of the activities listed below are already underway, while others will require additional funding to be implemented:

- Recommending state adoption of a single, standard definition of developmental disabilities,
- Establishing Community Services Boards (CSBs) as the single point of entry for the developmental disabilities service system,
- Developing an online training program and expanding the DBHDS community college certificate program for direct care professionals who serve individuals with ASD or other developmental disabilities,
- Transferring administration of the Medicaid Individual and Family Developmental Disability (DD) Waiver from the Department of Medical Assistance Services (DMAS) to DBHDS,
- Studying the feasibility and potential impacts of combining the Medicaid Intellectual Disability (ID) and DD Waivers into one comprehensive DD Waiver,
- Expanding Department of Rehabilitative Services (DRS) capacity to meet the growing demand for services for individuals with ASD, and
- Providing state recognition of ASD training developed by the Public Safety Workgroup as a minimum standard for public safety personnel and mandating basic ASD awareness training and ongoing in-service training for all public safety personnel.

DBHDS also engaged in a strategic planning process during state fiscal year (SFY) 2010 that involved over 200 individuals from consumer and provider groups who worked in teams to develop action steps that would address the system's most pressing issues. The result, *Creating Opportunities: A Plan for Advancing Community-Focused Services in Virginia* (www.dbhds.virginia.gov/documents/100625CreatingOpportunities.pdf), was adopted in June 2010. It identifies initiatives and major activities to be undertaken through SFY 2014 to ensure a responsive, well-managed service system for behavioral health and developmental disability services. DBHDS has established implementation teams for each strategic initiative and tasked them with developing detailed action steps, outcomes, and timelines. An update on these planning activities was published in 2011.

Additional changes to the shape and scope of community services for individuals with intellectual disabilities are anticipated in the Commonwealth's response to the February 2011 **U.S. Department of Justice (DOJ)** findings that the state is noncompliant with the "most integrated setting" tenets of the *Americans with Disabilities Act* (42 USC 12101 et seq.) and the 1999 U.S. Supreme Court decision in *Olmstead v. L.C.* (527 US 581). The DOJ investigation, covered in more detail in the Institutional Services chapter of this assessment, originally focused on the Central Virginia Training Center (CVTC) but was expanded in scope. DOJ found Virginia to be noncompliant based on its over-reliance on institutional care, as evidenced by its long Medicaid Home and Community Based Services (HCBS) Waiver waiting lists and its inadequate community infrastructure, including crisis intervention services.

During its 2011 session, the Virginia General Assembly approved several of Governor Bob McDonnell's budget proposals aimed at expanding the capacity of community supports, including an infusion of \$30 million in general funds into a **Behavioral Health and Developmental Services (BHDS) Trust Fund**. This fund will finance a broad array of community-based services including ID Waiver slots, one-time transition costs for community placements, community housing, and other identified community services needed to transition individuals with intellectual disabilities from the state's training centers to community residential settings. Legislation, including budget amendments, affecting Medicaid and Institutional Services are covered in those chapters of this assessment. Amendments restoring or partially restoring cuts proposed for community-based services in SFY 2012 included:

- \$188,279 for the Department of Rehabilitative Services' (DRS) Community (Long-Term) Rehabilitation Program case management services,
- \$194,931 to provide core safety net services such as case management, transitional day programs, and resource coordination for persons with brain injuries,
- \$160,000 for Centers for Independent Living (CILs), and
- \$5,000,000 to provide services for non-mandated youth under the *Comprehensive Services Act* (CSA).

The Virginia **Office of Comprehensive Services (OCS) for At-Risk Youth and Families** has been working closely with the **Department of Social Services (DSS)** to implement a three-year initiative, funded by the Annie E. Casey Foundation, focusing on the values and principles directing agency interactions with families and service providers. While not specifically targeted at children with disabilities, the **Children's Services System Transformation** changes how youth, particularly children in foster care or at risk of foster care placement, and their families get the help that they need to be more successful at home and in school, stay together, and preserve life-long family relationships. The initiative promotes training in child and family-centered best practices that involve family members, strengthen natural family supports, and increase the use of community-based services.

To better serve young people with brain injury who end up in the criminal justice system, the **Department of Rehabilitative Services' (DRS) Brain Injury Services Coordination**

(BISC) Unit is implementing **Closing the Gap**, a grant program funded by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services for 2009 through 2013. Funds granted to DRS will enable it to expand and strengthen the state's infrastructure for delivery of brain injury services and be matched by a sub-grant awarded to **Virginia Commonwealth University** to develop a brain injury screening protocol for all youth entering the **Department of Juvenile Justice (DJJ)** system and train DJJ staff in assessment and intervention. The HRSA funds cannot be used to provide direct services and, instead, will support public awareness, outreach, education and training, and interagency collaboration. By the fall of 2010, project staff had identified best practices for assessment and the screening protocol and had begun ongoing training for DJJ personnel in their implementation.

Anticipating rapid growth of the aging population, including those with disabilities, over the next decade, the 2008 General Assembly directed the **Virginia Department for the Aging (VDA)** to develop a four-year planning process for services to serve that population (*Code of Virginia, 2.2-703.1*). After extensive collaboration with and review of information by other agencies, service providers, gerontologists, and stakeholders at the state and local levels, VDA published its first *Four-Year Plan for Aging Services* in 2009 (www.vda.virginia.gov/pdfdocs/FourYearPlanForAgingServices-RD461-2009.pdf). This comprehensive review of services and challenges statewide for the elderly recommends changes need to more effectively meet both current and future needs and better leverage the human resources of older Virginians. Concurrent with this planning process, VDA and DRS have been exploring opportunities to collaborate and share resources to better integrate and coordinate services for individuals who are older or have disabilities, and in 2010, the DRS Commissioner was appointed as Interim-Commissioner for VDA to facilitate their joint efforts.

Since 2003, the federal **Administration on Aging (AOA)** and the **Centers for Medicare and Medicaid (CMS)** have collaborated to help states transform their long-term care service systems to better meet the needs of the growing number of individuals who are elderly or have disabilities using funds provided by AOA's **Aging and Disability Resource Centers (ADRC)** grant program. ADRC grants fund the creation and maintenance of one-stop points of access for long-term care information and services regardless of age or type of disability and encourage states to build effective service capacity and infrastructure that is person-centered and self-directed. More information on the Commonwealth's **No Wrong Door** initiative, a public and private joint effort led by VDA, can be found at www.vda.virginia.gov/nowrongdoor.asp.

In late 2010, VDA, the Partnership for People with Disabilities at Virginia Commonwealth University, the Area Agencies on Aging (AAAs), and the Centers for Independent Living in Virginia's seven No Wrong Door regions began work on a follow-up **ADRC Options Counseling** project. This two-year project, funded by AOA for just over \$513,000, will help persons who are older or have disabilities understand, evaluate, and manage the full range of services and supports available in their communities for long-term care and decision-making. The CILs have long provided this type of service for their clients, and

statewide standards are being developed to reflect equal perspectives from the aging and disability communities.

The **Community Living Program**, another relatively new AOA grant administered by VDA, is similar to the MFP and STG initiatives described earlier. It encourages states to use funding received under the *Older Americans Act* or other non-Medicaid sources for more flexible, consumer-directed services that support older individuals in “aging in place.” This strengthens the state’s ability to assist older individuals, who are at risk of nursing home placement and having to “spend-down” their assets to become eligible for Medicaid, remain in their homes and communities as independently as possible and experience an improvement in their quality of life through self-direction of services. The \$939,730 in federal funds received by VDA for this program will cover 23 percent of service costs with the balance coming from *Older American Act* funds, state general funds, and local funds.

Complementing all these efforts, the 2010 General Assembly directed the Secretary of Health and Human Resources (HHR) to lead an initiative to develop a **Blueprint for Livable Communities and Long-Term Care Services** for Virginians who are elderly or have a disability (*Code of Virginia*, 2.2-213.4). Drawing on existing reports and plans, multiple state agencies as well as other public and private organizations, led by VDA, have been developing a comprehensive statewide plan extending through state fiscal year (SFY) 2025. That plan must address “... (i) community integration and involvement, (ii) availability and accessibility of services and supports, and (iii) integration and participation in the economic mainstream.” The blueprint must be submitted to the Governor and legislative fiscal committees no later than June 30, 2011.

Since 2007, as detailed in the Community Housing chapter of this assessment, the **Statewide Independent Living Council (SILC)** has made a significant financial commitment of its federal funds to improve access to affordable, accessible housing for persons with disabilities, a essential component of all the community integration and self-determination efforts described above. The *Code of Virginia* (51.5-25.1) establishes the SILC as an independent planning and advocacy body charged with developing a three-year *State Plan for Independent Living* (www.vasilc.org/statewideindependentlivingcouncil.htm). Its members are appointed by the Governor to be representative of persons with significant disabilities from across the state, the Centers for Independent Living (CILs), and other recipients and providers of independent living services. The SILC’s goals include promoting individual empowerment and youth advocacy, assisting CILs with service to unserved and underserved populations, and supporting effective policies, programs, and activities that improve community-based services and maximize independence for Virginians with disabilities.

Along with the SILC, Virginia’s **Disability Services Boards (DSBs)** have long provided advice and assistance to the state’s system of community living supports for individuals with disabilities. Initially authorized in 1992 (*Code of Virginia*, 51.5-47), these boards were established to assist localities in identifying and addressing the needs of persons in their communities with physical and sensory disabilities. Some serve a single jurisdiction, and others

are multi-jurisdictional. DSB members include representatives of local government, business and industry, and the community at large. By statute, at least 30 percent of their members must be individuals with physical, visual, or hearing disabilities or members of their families. The scope and scale of DSB activities vary, dependent on their individual mix of public and private resources and local needs. The 2010 General Assembly eliminated DSBs as a mandated local function and, in 2011, eliminated state funding for their administration and management; therefore, their future is uncertain. As of late 2010, there were still 18 DSBs in existence statewide, with four transitioning into a different type of entity with a similar purpose. Ten were no longer active, and the status of eight previously established DSBs was unknown.

A description of all community-based programs and supports available to individuals with developmental and other disabilities is beyond the scope of this, or perhaps any, report. As noted at the beginning of this introduction, this chapter focuses on the services and supports that state agencies operate, administer, license, or pay for using state general funds or other financial resources including matching Medicaid funds. Details concerning services that can be accessed through the Medicaid State Plan and Medicaid Home and Community Based Services (HCBS) Waivers are covered in the Medicaid chapter of this assessment. The other community supports covered by this chapter are organized by the following key programs and services:

- Assistive Technology (AT) and Related Services,
- Brain Injury (BI) and Spinal Cord Injury (SCI) Services,
- Community Rehabilitation Case Management (CRCM) Services,
- *Comprehensive Service Act (CSA)*,
- Independent Living and Related Services,
- (Non-Waiver) Intellectual Disability Services,
- Interpreter Services and Related Programs for the Deaf and Hard of Hearing,
- *Omnibus Budget Reconciliation Act (OBRA) Services*,
- (Non-Waiver) Personal Assistance Services (PAS), and
- Services for the Elderly Population.

The array of community living services available to United States military personnel and veterans who have been injured during their service to the country is not a focus of this report. For the most part, these services are fully federally funded and provided by the U.S. Veterans Administration (VA); although, some rehabilitative services are offered by state disability agencies through Virginia's **Wounded Warrior Program** (<http://wearevirginiaveterans.org>). Veterans who sustain severe permanent injuries, such as traumatic brain or spinal cord injury, and are under the age of 22 at the time they are injured, however, may meet the definition of having a developmental disability and qualify for many of the services covered in this chapter on that basis. The state Department of Veterans Services (www.dvs.virginia.gov) can assist

individuals in accessing information, benefits, and services through the federally operated VA centers located statewide.

B. Eligibility for Community Supports

Assistive Technology (AT) and Related Services: Eligibility for AT, defined by state regulations (22 VAC 30-20-10) as "...any item, piece of equipment, or product system... that is used to increase, maintain or improve the functional capabilities of an individual with a disability," and related services varies by program. AT devices range from "reachers" and other simple mechanical aids to devices as complex as electric wheelchairs that responds to breath controls or adaptive environmental controls that respond to voice commands. AT services refer to "...any service that directly assists an individual with a disability in the selection, acquisition or use" of an AT device and may include:

- Functional evaluation of an individual in his or her natural environment;
- Leasing or providing AT equipment;
- Customizing, maintaining, repairing, or replacing AT;
- Training or technical assistance in using AT for an individual with a disability and, as appropriate, for his or her family, guardian, or authorized representative); or
- Training or technical assistance to professionals, employers, or others who employ, serve or "are substantially involved in the major life functions of individuals with disabilities" in order to achieve an employment outcome.

The **Department of Rehabilitative Services (DRS)** provides AT services for individuals with disabilities of all ages and levels of ability through its **Virginia Assistive Technology System (VATS)**, as authorized by the federal *Assistive Technology Act* of 2004, as amended, and its **Virginia Reuse Network (VRN)**. Applications for VATS assistance are available online (www.vats.org), by phone, or at each of its regional offices. VRN programs (www.vats.org/atrecycling.htm) vary in the devices and services that they provide, with program-specific waivers of liability and other forms that can be completed when an individual comes in to select a needed device.

DRS' **Woodrow Wilson Rehabilitation Center (WWRC)** in Fishersville, Virginia, provides adolescents and adults with disabilities from across the state with a variety of AT services through outpatient clinics and residential programs. Priority is given to current DRS clients for whom AT is urgently needed to obtain or keep a job, and its more intensive residential AT services have more specific eligibility criteria than its outpatient programs. Detailed eligibility information is available on WWRC's website (www.wwrc.virginia.gov/admissions.htm) or by contacting the facility directly.

The **Technology Assistance Program (TAP)** of the **Virginia Department for the Deaf and Hard of Hearing (DDHH)** provides AT services (www.vddhh.virginia.gov/TechIntro.htm)

for individuals who are deaf, hard of hearing, deafblind or otherwise both hearing and vision impaired, or who have speech impairments that prevent them from using a standard telephone. To be eligible, an individual's disability must be verified by a licensed professional, a DDHH outreach specialist, or an appropriate representative of DRS, the Department for the Blind and Vision Impaired (DBVI), or the Virginia School for the Deaf and Blind. Individuals must also provide proof of residency and meet financial guidelines. Income limits are based on the federal poverty level (FPL) and may vary from year to year. The current limit is an income of no more than 250 percent of FPL. There are no age restrictions, but applications for children and youth under age 18 must be cosigned by a parent or legal guardian. Eligible applicants are served first-come, first-served based on available funds. DDHH may give priority to new applicants or to recipients who have not received AT equipment in the previous four years and who do not have functioning equipment, as verified by DDHH or a vendor. Fees for services are determined by a sliding scale based on ability to pay.

The **NewWell Fund** (www.newwellfund.org), administered by the public Assistive Technology Loan Fund Authority (ATLFA), assists Virginia residents with disabilities, as defined for the program's purposes, and their families in securing low-interest loans to purchase AT devices or related services. Assistance is also available for a small business or nonprofit organization if they can demonstrate that the loan will be used to acquire AT for employment or retention of one or more persons with disabilities or will be used to make structural modifications consistent with the *Americans with Disabilities Act* (ADA) that will benefit people with disabilities. Prospective borrowers must demonstrate their creditworthiness and repayment ability, based on credit history, income, and debt, to the satisfaction of the NewWell Fund; however, individuals with either no credit history or poor credit due to disability or medical issues are given special consideration.

Brain Injury (BI) and Spinal Cord Injury (SCI) Services: Services for persons with brain or spinal cord injuries are designed to facilitate community reintegration and personal independence. Outreach, information, and referral services for persons with brain injury are provided by the **Brain Injury Services Coordination (BISC) Unit** located within the Community Based Services Division of the Department of Rehabilitative Services (DRS). Individuals with brain or spinal cord injuries may also apply directly or be referred by DRS counselors for services from the two corresponding programs at DRS' Woodrow Wilson Rehabilitation Center (WWRC) mentioned above.

The **WWRC Brain Injury Services Department** (www.wwrc.virginia.gov/braininjuryservices.htm) serves individuals with either traumatic or non-traumatic acquired brain injury. Those individuals must be "...medically, physically, and psychologically stable with a favorable prognosis for participating in, completing, and benefiting from the services," and their current behavior must be unlikely to jeopardize the health and safety of themselves or others or to jeopardize the rehabilitation program. Applicants with a co-occurring psychiatric diagnosis or a history of substance abuse must be able to demonstrate six consecutive months of stability. As a part of the application and referral process, an individual must typically complete a one-day

feasibility outpatient evaluation at WWRC to clarify his or her current neuro-behavioral functioning and what services are needed.

Individuals eligible for the **WWRC Spinal Cord Injury Services** (www.wwrc.virginia.gov/spinalcordinjury.htm) must be medically stable following spinal cord injury or disease and have the potential to benefit functionally from the comprehensive rehabilitation evaluation and treatment services that it offers. As noted previously, DRS clients pursuing vocational goals are given priority.

The DRS BISC Unit also administers the **Brain Injury Direct Services (BIDS) Fund** that supports rehabilitation enabling individuals to live more independently and progress in their recovery. To be eligible for assistance, individuals must:

- Have a documented acquired brain injury,
- Be at least one year post-injury,
- Reside in an institution or be at risk of institutionalization,
- Have completed acute care hospitalization and medical rehabilitation stages of recovery,
- Have no other public or private source of funds available (such as Medicaid, private insurance, or other DRS assistance),
- Meet DRS financial eligibility or be willing to share in the cost of services, and
- Have a family or other support person willing to participate in the program.

The required written application for BIDS Funds is available online; however, because these funds are limited, individuals are encouraged to contact the BISC Unit (www.drs.virginia.gov/cbs/biscis.htm) prior to submitting an application to verify that funds are available.

Community Rehabilitation Case Management (CRCM) Services: This program operated by the Department of Rehabilitative Services (DRS) matches individuals who have severe physical or sensory disabilities with appropriate community services and supports. As a result of their disability, these individuals must require a special combination of life-long or extended duration services and have substantial limitations in three or more of the following life areas: communication, independent living, mobility, learning, self-care, self-direction, or economic self-sufficiency. Residents of skilled nursing facilities are eligible for CRCM Services, including transition to community assistance, through the *Omnibus Budget Reconciliation Act* (OBRA, see below) Nursing Home Outreach Service. CRCM Services also provides support coordination (case management) for a limited number of individuals under the Medicaid Home and Community Based Services (HCBS) Individual and Family Developmental Disability (DD) Waiver.

CRCM Services applicants must meet disability and financial eligibility requirements based on the service being requested, and because resources are limited, the priorities listed

below exist for accessing CRCM Services support coordination services. At all priority levels, preference is given to public safety officers and military veterans disabled in the line of duty.

- Priority I: Individual is in danger of being placed in a psychiatric facility, nursing home, or other institutionalized setting or is approved for short-term services through the DRS Brain Injury Direct Services (BIDS) Fund.
- Priority II: Individual has no support service system in place and is not receiving service coordination services through any agency or organization.
- Priority III: Individual has an identified need for case management that will improve overall quality of life and access to needed supports and services.
- Priority IV: Individuals who meet program eligibility requirements will be considered in order of application.

Comprehensive Services Act (CSA): This goal of this statute (*Code of Virginia, 2.2-5200 et seq.*) is to "...create a collaborative system of services and funding that is child-centered, family focused, and community based when addressing the strengths and needs of troubled and at-risk youth and their families..." Because it pools eight funding streams across four state agencies for which multiple federal mandates must be met, multiple eligibility criteria for services under the CSA exist. To be eligible, children and youth must be younger than either age 18 or 22, depending on the service, and, in general, would have been eligible for services through one of its eight funding streams.

The CSA targets the following five populations, of which only the first three are mandated for services:

1. Children placed in approved private school education programs for purposes of special education previously funded by the Department of Education through private tuition assistance;
2. Children with disabilities placed by local social services agencies or by the Department of Juvenile Justice in private residential facilities or across jurisdictional lines in private special education day schools, if the individualized education program indicates such school is the appropriate environment in which to receive services while living in foster homes or child-caring facilities;
3. Children for whom foster care services, as defined by the *Code of Virginia* (63.2-905), are being provided to prevent foster care placements and children placed through parental agreements, entrusted to local social service agencies by their parents or guardians, or committed to the agencies by any court of a competent jurisdiction;
4. Children placed by a Juvenile and Domestic Relations District Court in a private or locally operated public facility or nonresidential program or in a community or facility-based treatment program; and
5. Children committed to and placed by the Department of Juvenile Justice into a private home or in a public or private facility in accordance with the *Code of Virginia* (66.14).

The CSA further requires that one or more of the following criteria be met for an individual described above to receive services under the statute (*Code of Virginia*, 2.2-5212[A]):

1. “The child or youth has emotional or behavior problems that:
 - a. “Have persisted over a significant period of time or, though only in evidence for a short period of time, are of such a critical nature that intervention is warranted;
 - b. “Are significantly disabling and are present in several community settings, such as at home, in school or with peers; and
 - c. “Require services or resources that are unavailable or inaccessible, or that are beyond the normal agency services or routine collaborative processes across agencies, or require coordinated interventions by at least two agencies.
2. “The child or youth has emotional or behavior problems, or both, and currently is in, or is at imminent risk of entering, purchased residential care. In addition the child or youth requires services or resources that are beyond normal agency services or routine collaborative processes across agencies, and requires coordinated services by at least two agencies.
3. “The child or youth requires placement for purposes of special education in approved private school educational programs.
4. “The child or youth has been placed in foster care through a parental agreement between a local social services agency or public agency designated by the community policy and management team and his parents or guardian, entrusted to a local social services agency by his parents or guardian, or has been committed to the agency by a court of competent jurisdiction for purposes of placement” as authorized by the *Code of Virginia* (63.2-900).

Localities may choose to serve non-mandated youth with emotional or behavioral problems who meet CSA eligibility criteria; however, there is no legal requirement that local governments provide the matching funds to do so. The **Office of Comprehensive Services (OCS) for At-Risk Youth and Families** (www.csa.virginia.gov) that administers the CSA reports that 93 percent of the children and youth served in state fiscal year (SFY) 2007 and 92 percent of those served in SFY 2010 were categorized as mandated.

Independent Living and Related Services: Training and support in areas such as self-advocacy and assertiveness, stress management, communication, social and relationship skills, home management, personal hygiene and wellness, meal planning and preparation, shopping, and money management make it possible for individuals with significant disabilities to maintain or increase their self-reliance. Although a variety of public and private entities offer these services, they are primarily provided by the state’s **Centers for Independent Living (CILs)** and the **Rehabilitation Teaching/Independent Living (RT/IL) Program** of the Department for the Blind and Vision Impaired (DBVI).

The Commonwealth's CIL program (www.drs.virginia.gov/cbs/cils.htm), authorized under the federal *Rehabilitation Act* of 1932 as amended (PL 93-112) and the *Code of Virginia* (51.5-23-25), funds community-based, cross-disability, non-residential agencies operated by and for individuals with disabilities. Anyone with a significant disability is eligible for services from a CIL in the localities across the state where they exist. The *Rehabilitation Act* defines an individual with a significant disability as someone with a significant physical or mental impairment whose ability to function independently in the family or community or to obtain, maintain, or advance in employment is substantially limited. The statute further specifies that services should be provided when they will improve the individual's ability to function, continue functioning, move toward independent functioning in the family or community, or improve his or her ability to continue in employment.

The DBVI RT/IL program (www.vdbvi.org/RTILS.htm) specifically targets individuals who are blind or have related visual or sensory impairments and provides services enabling those individuals to maximize their economic, social, and personal independence and participation in community life. The program funds services for more than 267,000 Virginians of all ages. Eligibility for RT/IL services requires verification of residence and medical documentation of the nature and scope of the vision impairment. Generally, an individual must have, in the better eye, visual acuity (with correction if needed) that is worse than 20/70 or a visual field that is less than 70 degrees across. Once basic eligibility has been determined, the individual can be referred to the Orientation and Mobility Program, DeafBlind Services, Low Vision Services, or other DBVI programs based on needs identified through a functional assessment by a DBVI Rehabilitation Teacher. Financial participation requirements, based on a formula intended to identify individuals with the greatest economic need, exist for the purchase of some equipment. Financially eligible individuals receive tangible goods and services at no cost. Those declared financially ineligible may be required to pay some or all of the costs for certain goods and services. Financial eligibility criteria are updated annually.

Independent living services may also be obtained from **Employment Service Organizations (ESOs)** that are authorized to provide these services by the Department of Rehabilitative Services (DRS). ESO independent living services approved by DRS may or may not be related to vocational rehabilitation. Additional information on ESOs and the services that they provide can be found in the Employment chapter of this assessment.

(Non-Waiver) Intellectual Disability Services: The **Virginia Department of Behavioral Health and Developmental Services (DBHDS)** is responsible for planning, monitoring, and overseeing publicly funded services for individuals with intellectual disabilities. To do so, it contracts with 37 independent, local **Community Services Boards** and three **Behavioral Health Authorities** (collectively referred to as **CSBs**) that are designated by the *Code of Virginia* (37.2-500 and 37.2-601) as the single point of entry into the state's mental health, intellectual disability, and substance abuse services system.

In addition to a diagnosis of intellectual disability, eligibility requirements for specific services vary by their nature and funding availability. CSBs determine whether individuals are

eligible, coordinate service delivery, and often provide the services themselves. At the time of this assessment, individuals with developmental disabilities who do not have a concurrent intellectual disability are not eligible for CSB services unless a locality has chosen to offer them and has the resources to do so. The designation of DBHDS as the lead state agency for individuals with developmental disabilities, including autism spectrum disorders (ASDs), has so far not been accompanied by additional funding for it or the CSBs to provide services for this expanded population.

Interpreter Services and Related Programs for the Deaf and Hard of Hearing: The Interpreter Services Program (www.vddhh.virginia.gov/IpAbout.htm), administered by the **Department for the Deaf and Hard of Hearing (DDHH)**, provides critical communications services for Virginians of any age who are the deaf, hard of hearing, deafblind, or have speech impairments and use sign language. The *Code of Virginia* (51.5-113) authorizes DDHH to coordinate the services of sign language interpreters for all state agencies. This includes colleges and universities; however, DDHH contracts do not cover interpreters in higher education.

Various state laws mandate court appointment of interpreters for individuals who are deaf. In each of these instances, the cost for interpreters is borne by the state; however, the person who is deaf may waive his or her right to a court-appointed interpreter and provide one at his or her personal expense. Individuals who are deaf are entitled to a court-appointed interpreter by statute when they are:

- Alleged to have a mental illness or intellectual disability and facing commitment or certification (37.2-802 and 37.2-815,;
- A party or a witness to a civil proceeding and request such assistance (8.01-384.1),
- Involved in a criminal case as either the victim of or witness to a crime (19.2-164.1), or
- Accused under trial in a criminal case (19.2-164.1).

DDHH also administers the federally mandated **Virginia Relay** system (www.varelay.org) for individuals who are deaf or hard of hearing and those who want to communicate with them. Virginia Relay provides traditional voice-carry-over, hearing-carry-over, and voice-to-voice services for individuals with hearing loss or speech impediments as well as new CapTel technology that transmits both voice and text. Additional information about the different types of service as well as an application to obtain one of the limited number of CapTel devices available from DDHH are available on the Virginia Relay website.

Omnibus Budget Reconciliation Act (OBRA) Services: This federal statute (PL 100-203), passed in 1987, requires states to evaluate individuals with intellectual disabilities or related conditions being considered for admission to a Medicaid-funded nursing facility to determine whether they require that level of services. Then, for individuals admitted to a facility, a determination must be made whether they continue to need nursing facility care whenever a resident review indicates a significant change in condition or at least annually. As a part of these evaluations, it must also be determined what specialized services are needed to maximize self-

determination and independence for these individuals and whether they can benefit from receipt of those services. When a resident is determined to no longer need nursing facility level of care or chooses community-based services, the state must begin the discharge process, including resident preparation and arrangements for or provision of those specialized services when they are not provided by the nursing facility or covered under the Medicaid State Plan.

In Virginia OBRA requirements (www.dbhds.virginia.gov/omh-obra.htm) are collaboratively fulfilled by the **Department of Medical Assistance Services (DMAS)**, **Department of Rehabilitative Services (DRS)**, and **Department of Behavioral Health and Developmental Services (DBHDS)**. DBHDS is responsible for the pre-admission screening and subsequent evaluations, determination of specialized service needs, and providing or arranging for delivery of those services. Typically, individuals eligible for services under OBRA have a significant disability arising from cerebral palsy, epilepsy, autism, brain or spinal cord injury, muscular dystrophy, multiple sclerosis, spina bifida, stroke, or other conditions of neurological origin. Persons with developmental, including intellectual, disabilities eligible for services under OBRA must have a significant disability that was evident before age 22, and a determination must be made that the individual needs and can benefit from specialized services.

(Non-Waiver) Personal Assistance Services (PAS): Individuals with physical disabilities, such as spinal cord injuries, cerebral palsy, and muscular dystrophy, who require assistance from another person to perform nonmedical activities of daily living and are not eligible for these services under vocational rehabilitation, a Medicaid Home and Community Based Services (HCBS) Waiver, or any other program may be eligible for personal assistance services (PAS) through one of two programs by the **Department of Rehabilitative Services (DRS)**. To qualify for consumer-directed, **State-Funded PAS** (www.drs.virginia.gov/cbs/pas.htm) or **PAS for Individuals with Brain Injury (PAS/BI)**, an individual must submit an application for services, after which an assessment is made to determine service needs and ascertain whether comparable services can be obtained from any other source. If funding becomes available to serve additional participants, assessments are conducted for each applicant, and selection for services is based on severity of need.

Additional information on consumer direction appears in the Medicaid chapter of this assessment. PAS/BI is only available for a limited number of individuals (four to eight) who wish to designate a representative to assist them in managing their PAS services. Vocational rehabilitation services by DRS and the Department for the Blind and Vision Impaired (DBVI), which may include PAS, are covered in the Employment chapter.

Services for the Elderly Population: While many state agencies provide services across the lifespan, the **Virginia Department for the Aging (VDA)** is responsible for oversight of all state programs funded through the federal *Older Americans Act*, as amended in 2006 (PL 109-365), and certain related appropriations by the Virginia General Assembly. These programs are coordinated and provided by VDA in contractual partnership with local **Area Agencies on Aging (AAAs)** that tailor their services to the needs of local residents (www.vda.virginia.gov/aalist.asp).

AAAs offer information, referrals, and technical assistance to anyone in their area ages 60 and over or ages 18 through 59 with disabilities, their family members, and caregivers. For other AAA services, individuals must be age 60 or over, except for the **Title V Senior Community Service Employment Program** that serves Virginians ages 55 and over. Priority for services is given to older individuals who are in the greatest economic and social need and to those who are at risk for institutional placement. Preference is also given to older individuals who are part of a low-income minority population, have limited English proficiency, or live in rural areas. Adult caregivers of older individuals or individuals under age 50 with early onset dementia are eligible for services under the **National Family Caregiver Support Program (NFCSP)**. Family members who are aged 55 and over who are caring for children ages 18 and under or adults ages 18 through 59 with a severe disability may also receive NFCSP services. Some AAA in-home and community services are provided on a sliding fee scale based on an individual's ability to pay.

As noted in the introduction to this chapter, the VDA's **Community Living Program** (www.vda.virginia.gov/communityliving.asp) that helps Virginians age in place is a relatively new initiative being piloted in ten AAAs. The AAAs involved in the program identify and enroll participants, offer consumer-directed services, and participate in program evaluation activities. To be eligible for the program, individuals must meet all of the following criteria:

- Be 65 years of age or older,
- Have a family caregiver who demonstrates difficulty meeting the individual's needs,
- Need assistance because of either a cognitive impairment or an impairment in at least two activities of daily living (ADLs),
- Have income at or below 300% of Social Security Income (\$2,022 a month at the time of this assessment), and
- Likely for denial of Medicaid eligibility due to excess liquid resources such as savings, bonds, or certificates of deposit.

The **Public Guardianship Program** (www.vda.virginia.gov/vapublicguardpgm.asp), also managed by VDA, funds local human service agencies that provide those services for persons aged 18 and over, not just the elderly, who have been determined to be unable to care for themselves or make decisions about their care (are "incapacitated"), are indigent, and do not have a suitable person willing or able to serve as their decision-maker. Due to funding limitations, this program is not available in all areas of the state and cannot fund services for all individuals needing them.

In addition to the above programs by the VDA and AAAs, the **Department for the Blind and Vision Impaired (DBVI)** administers the **Older Blind Grant Program** (www.vdbvi.org/RTILS.htm) for Virginia residents ages 55 and over who have documented blindness or a severe visual impairment that significantly interferes with normal life activities. DBVI staff provide free assessments, one-on-one training, and instructional services for all individuals; however,

financial eligibility requirements must be met for coverage of costs associated with such services as the provision of adaptive equipment for individuals who are blind or vision impaired.

The **Program of All-Inclusive Care for the Elderly (PACE)**, a Medicaid State Plan optional service funded and administered by the **Department of Medical Assistance Services (DMAS)** is another program specifically targeted at older Virginians (http://dmasva.dmas.virginia.gov/Content_pgs/ltc-pace.aspx). PACE provides the entire continuum of medical care and supportive services needed by Virginians age 55 and over to age in place and remain in community-based settings, avoiding more restrictive and costly institutional placement. To be eligible for PACE, state regulations (12 VAC 30-120-63) specify that an individual must:

- Be 55 years or older;
- Meet level of care criteria for a nursing home or, if an individual with an intellectual disability, the level of care of an intermediate care facility for persons with mental retardation (ICF-MR);
- Reside in the service area of a PACE organization; and
- Have his or her health, safety, and welfare “assured in the community.”

Individuals who are eligible for Medicaid or dually eligible for both Medicaid and Medicare are also eligible to enroll in PACE. Generally, income must be equal to or less than 300 percent of the current Supplemental Security Income (SSI) payment standard for one person, and their financial resources must be equal to or less than the resource allowance established in the current Medicaid State Plan. Other eligibility requirements may be specified under the PACE program agreement with providers. To determine eligibility, a preadmission screening team under contract with DMAS conducts a formal evaluation of an individual using the Uniform Assessment Instrument (UAI), a standardized questionnaire (*Code of Virginia, 32.1-330*). PACE also accepts individuals who pay privately and meet other eligible criteria.

C. Access to and Delivery of Community Supports

Assistive Technology (AT) and Related Services: These services may be provided on an outpatient basis in an office, in the individual’s home, or within a residential program. Sources of AT services and equipment include local school divisions, vocational rehabilitation agencies, private vendors on a fee-for-service basis, and other local programs. Each has its own process for access and delivery, and an individual with a disability may have access to AT through multiple programs at different times based on different needs. In addition to their basic procedures, each source of AT has its own appeals process, such as mediation and informal or formal hearings, to deal with situation in which individuals with disabilities, their family members, and service providers disagree on the need for or type of AT.

The **Department of Rehabilitative Services’ (DRS) Virginia Assistive Technology System (VATS)** provides services through its central office in Richmond and three regional sites: Southwest VATS at Virginia Tech in Blacksburg, Southeast VATS at Old Dominion

University in Norfolk, and Northern VATS at George Mason University in Fairfax. Information, referrals, and other assistance are also available by phone (800-552-5019, toll-free) or online (www.vats.org/contactus.htm). During federal fiscal year (FFY) 2010, VATS made 51 loans of AT equipment, conducted 128 demonstrations and 2,098 trainings, and provided information or other assistance to 2,096 contacts.

In addition to VATS regional university sites, DRS' **Woodrow Wilson Rehabilitation Center (WWRC)** provides comprehensive technology assessments and customized technology services through a variety of programs. Policies and access procedures vary among the programs, dependent on the needs of the individuals that they serve. WWRC program teams may include rehabilitation and computer systems engineers, physical and occupational therapists, speech/language pathologists, and social workers, as needed. Additional information is available online, from a widely distributed interactive CD-ROM, or by contacting WWRC directly.

The table below shows the substantial increase in the number of individuals receiving AT services through WWRC programs from state fiscal year (SFY) 2007 to SFY 2010. While most clients still receive services through outpatient programs, recent growth in residential services (64 percent) has exceeded that for outpatient services (53 percent).

**NUMBER OF PERSONS RECEIVING ASSISTIVE TECHNOLOGY SERVICES
THROUGH THE WOODROW WILSON REHABILITATION CENTER (WWRC)**

Type of Program	SFY 2007	SFY 2010	Change	Percent
Residential	58	95	+37	+64%
Outpatient	258	394	+136	+53%
Total	316	489	+173	+55%

Source: Department of Rehabilitative Services (DRS).

Since October 2010, new grant funds have enabled VATS, WWRC, and the Foundation for Rehabilitation Equipment and Endowment (F.R.E.E.) to collaboratively build and administer a statewide **Virginia Reuse Network (VRN)** to help meet the rehabilitation equipment needs of Virginians with disabilities, particularly those who lack resources to purchase this equipment on their own. Local public and private partners supply VRN with volunteers and generate donations of gently used rehabilitation equipment and funds. This equipment is sanitized, repaired or refurbished, and redistributed through regional recycling centers (www.vats.org/atrecycling.htm).

During FFY 2010, VRN provided recycled AT to 418 individuals, bringing the total number of individuals served by statewide reuse programs since FFY 2006 to 8,025. These individuals have received 9,537 devices valued at \$3,473,646. Over the next three years, using funding from the Commonwealth Neurotrauma Initiative (CNI), the federal *American Recover and Reinvestment Act (ARRA)* and *Assistive Technology Act*, VRN plans to build further capacity to more effectively serve persons with spinal cord injuries, traumatic brain injuries, veterans with disabilities, and DRS vocational rehabilitation participants.

Individuals seeking information or services from the **Virginia Department for the Deaf and Hard of Hearing's (DDHH) Technology Assistance Program (TAP)** may contact either DDHH or one of its 15 local **Loan-To-Own (L2O)** providers. During the two years prior to this assessment, DDHH completed transition from its previous system of TAPLoan centers across the Commonwealth to its new L2O contractual outreach program. While the four remaining TAPLoan centers no longer have a contractual agreement with DDHH and new equipment is no longer available through those sites, access to AT has not decreased as a result of this transition. Through TAP L2O, a qualified individual has the opportunity to test various technologies and devices designed to enhance independence and quality of life for persons with hearing loss. At the end of a 30-day loan period, if a device meets his or her communications needs, ownership is permanently transferred. During the loan period, if the device is not meeting his or needs, the individual may exchange it for a different device to test in the home or workplace for an additional 30 days. All devices carry a one-year warranty, and qualified TAP participants can apply for new equipment every four years.

In state fiscal year (SFY) 2007, TAP provided equipment to 523 eligible individuals, a decrease of 13.3 percent from the 603 served in SFY 2005. Full implementation of the TAP L2O program improved access to AT through online submission of applications, decentralization of equipment inventory, and elimination of waiting times for receipt of equipment. As a result, the number receiving equipment increased by 110 percent to 1,099 in SFY 2010. An additional 1,834 individuals received technical assistance that year, and as of July 1, 2011 TAP has been entirely funded through state special funds, not general funds.

DDHH also provides generalized outreach services that include training, technical assistance, information and referral, and library services. During SFY 2010, it had a total of 37,779 outreach program contacts, down significantly from 71,141 in SFY 2007. Two main factors contributed to this decrease. DDHH funding for outreach contracts was reduced by 30 percent, and its library was closed due to budget reductions and declining circulation.

The **Virginia Relay** system administered by DDHH can be accessed by dialing 7-1-1 on any phone. Traditional relay service for individuals with hearing or speech impairments uses an intermediary confidential Communications Assistant who converts text messages created on a TTY or similar device to voice and vice versa. As noted earlier, newer CapTel technology for individuals who have speech impairments but can still hear or who still have partial hearing ability transmits both voice and text. Individuals who use these services are encouraged to complete a Relay Choice Profile that automatically notifies the Communications Assistant of their calling preference. **Video Relay Service** is a fast growing feature of Virginia Relay that enables sign language users to communicate in their native language using a special video device. DDHH outreach contractors across the state can provide information, demonstrate the use of videophones, and provide technical assistance.

Virginia Relay's 105 Communications Assistants, located at its center in Norton, provide relay service 24 hours per day for every day of the year. They can also provide technical assistance and respond to comments and suggestions from the system's users. By law, they must

communicate users' typed or spoken words exactly as provided and maintain absolute confidentiality about all conversations. While the relay service is free, individuals must still pay their telecommunications providers' usual call costs. Overall use of Virginia Relay declined by 13.7 percent from 1,908,328 calls during SFY 2007 to 1,647,424 in SFY 2010, and the number of traditional TTY-based relay calls has dropped by 58 percent since 2004. This trend is directly attributable to the emergence of internet and wireless alternatives to relay services that allow individuals to communicate directly using text messaging, video, and other technologies.

On April 15, 2011, the maximum amount of loans made by the **NewWell Fund** directly to individuals and home-based businesses for assistive technology or other adaptive equipment, when the applicant is the full guarantor, was increased from \$15,000 to \$22,500. For loans greater than that amount, it partners with SunTrust Bank, and applicants must meet SunTrust's normal underwriting standards. When an applicant is unable to meet SunTrust's requirements on his or her own, the NewWell Fund may guarantee the loan. For this to happen, the applicant must first be rejected by the bank, then provide the NewWell Fund with satisfactory assurances of creditworthiness and ability to repay the loan. In determining whether these assurances are satisfactory, the NewWell Fund will overlook credit issues related to the applicant's disability. Loan application forms are available at www.atlfa.org/loanapplication.htm.

Resources supporting NewWell Fund loans include federal grants, state appropriations, and matching public and private contributions. While it primarily uses these resources for loans to individuals with disabilities, some are set aside for repayment of defaults, as necessary, and to reduce interest rates on all loans, further reducing individuals' loan obligations. The table below summarizes NewWell Fund loan activities for the past five state fiscal years (SFY).

NEWWELL FUND LOAN ACTIVITY

State Fiscal Year	2006	2007	2008	2009	2010
Loan Requests Processed	232	232	231	205	231
Types of Loans Approved					
Direct Loans	75	56	65	74	92
Nonguaranteed Loans	24	27	33	6	15
Guaranteed Loans	28	22	24	9	9
Total Loans Approved	127	105	122	89	116

Source: NewWell Fund.

While the total number of NewWell Fund loan requests processed and approved has remained relatively stable over this period, the number of direct loans has increased over the entire period and by 64 percent from SFY 2007 to SFY 2010. Their proportion has also increased, and in SFY 2010, they made up 79 percent of all loans approved. During that year, AT purchased by loan recipients included 20 hearing aids, 67 adapted vehicles or vehicle modifications, 15 environmental or home modifications, eight mobility devices, two prostheses, three computers and related software, one piece of recreational or sports equipment, and one tool of trade.

Brain Injury (BI) and Spinal Cord Injury (SCI) Services: As the state's lead agency for planning and monitoring services for individuals with acquired brain injury, the **Department of Rehabilitative Services' (DRS) Brain Injury Services Coordination (BISC) Unit** manages specialized brain injury services offered through contractual agreements with nine providers that operate 12 programs statewide at a total cost of \$3.8 million. The unit also provides support, technical assistance, and training for public and private providers of brain injury services.

BISC staff serve as an initial point of contact for other DRS personnel and external customers who need resource or referral information about brain and spinal cord injuries in general or information about specific agency services for persons with neurotrauma. Typically, in order to effectively serve individuals with brain or spinal cord injuries, an interdisciplinary support team works with the individual and his or her sponsor or family members or caregivers, at the individual's discretion, to develop and achieve vocational and independent living goals. BISC staff also work closely with DRS field staff to resolve customer concerns regarding agency services for persons with brain and spinal cord injuries.

The DRS **Brain Injury Direct Services (BIDS) Fund**, which has had limited resources, served only 18 individuals in state fiscal year (SFY) 2005, 30 in SFY 2007, and 15 in SFY 2010. Due to anticipated budget cuts, BIDS Fund expenditures for SFY 2010 were limited. Funds in the amount of \$22,500 were transferred to serve four additional individuals through the Personal Assistance Services for Individuals with Brain Injury (PAS/BI) program. The remaining \$18,317 were used for other client services. To maximize use of the BIDS Fund in SFY 2011, the DRS Commissioner has directed that each of the 12 contracted brain injury services programs receive an additional \$5,000, a total allocation of \$60,000, to create a more efficient, effective way of accessing funds in a timely manner. DRS retained a small balance of the funds to purchase goods and services for those who meet eligibility requirements but are not served by a state-funded brain injury program.

The DRS BISC Unit has a collaborative relationship with the **Woodrow Wilson Rehabilitation Center's (WWRC) Brain Injury Services (BIS) Department** and **Spinal Cord Injury (SCI) Services** program. A WWRC staff member serves on the Virginia Brain Injury Council and another is involved in WWRC's strategic planning for brain injury services.

The table below shows the number of individuals with brain injury served by the BIS Department and SCI Services at WWRC for selected years between SFY 2005 and 2010. The SCI Services counts do not include individuals with spinal cord injuries who may have been served by other programs at WWRC.

**INDIVIDUALS RECEIVING BRAIN AND SPINAL CORD INJURY SERVICES
AT WOODROW WILSON REHABILITATION CENTER (WWRC)**

WWRC Department/Program	SFY 2005	SFY 2007	SFY 2010
Brain Injury Services	123	132	132
Spinal Cord Injury Services	148	166	200

Source: Department of Rehabilitative Services (DRS).

The number of individuals served by the WWRC BIS Department increased by 7.3 percent between SFY 2005 and SFY 2007, then remained stable for SFY 2010; however, at the end of both SFY 2007 and SFY 2010, it had a waiting list of 14 individuals needing but not able to receive services. In comparison, the number served by SCI Services grew by 12.2 percent from SFY 2005 to SFY 2007 and an additional 20.5 percent between SFY 2007 and SFY 2010. Improvements to WWRC's data system in SFY 2010 allowed it to also track individuals with spinal cord injuries receiving services from its programs other than SCI services, a total of 27 individuals in addition to the 200 reported above.

Community Rehabilitation Case Management (CRCM) Services: This **Department of Rehabilitative Services (DRS)** program links individuals with disabilities and their families to the services that they need, coordinating and monitoring service delivery both to ensure that clients' evolving needs are met and eliminate, reduce, or prevent personal and economic dependency. CRCM Services are provided at no cost to individuals who meet disability and financial eligibility requirements through a Richmond central office and regional offices in Abingdon, Christiansburg, Fishersville, Fredericksburg, Hampton, Lynchburg, Portsmouth, and Richmond (www.vadrs.org/cbs/ltrcm.htm).

The number of individuals who can receive CRCM Services varies from year to year due to the program's limited capacity and variability in individuals' service needs. The table below contains data from the DRS 2010-2012 *Agency Strategic Plan* for selected years between SFY 2005 and SFY 2010 plus the actual and percent change for that entire period.

**NUMBER SERVED AND ON THE WAITING LIST
FOR COMMUNITY REHABILITATION CASE MANAGEMENT SERVICES**

State Fiscal Year	2005	2007	2010	Change	Percent
Number Served	526	581	708	+182	+34.6%
Number on Waiting List	250	105	79	-171	-68.4%
Total	776	686	787	+11	+1.4%

Source: Department of Rehabilitative Services (DRS).

As show above, the number of individuals needing CRCM Services remained relatively steady between SFY 2005 and SFY 2010 but exceeded the capacity for services resulting in a waiting list. During this time, however, DRS was able to increase the number served by 34.6 percent, reducing the waiting list by 68.4 percent, nearly eliminating it.

Comprehensive Services Act (CSA): The state **Office of Comprehensive Services (OCS) for At-Risk Youth and Families'** objectives in administering the services provided under this statute are to: (1) ensure that services are consistent with state policies for family preservation and for treatment in the least restrictive environment, (2) intervene early with youth who are at risk of developing emotional or behavioral problems and their families, and (3) increase family involvement in service delivery and management. To achieve these objectives OCS encourages partnerships and collaborations between public and private agencies in the design and delivery of

services that are responsive to the unique strengths and needs of troubled youths and their families.

Localities are required to have at least two different interagency teams as part of the process for determining access to the CSA system but, otherwise, are permitted to develop their own policies and procedures. The **Community Policy and Management Team (CPMT)** has administrative and fiscal responsibility for managing the local and state pool of funds, developing local interagency policies and procedures for referral and assessment, planning long-range community services, conducting quality assurance and utilization reviews, and appointing members to the locality's **Family Assessment and Planning Team (FAPT)**. Some localities allow parents to contact the CPMT or FAPT teams directly, while others require a local agency to bring a case before them, and many require that one of its team's participating agencies serve as the point of contact for a family. To learn how to access CSA in a locality, individuals may call the CPMT Chairperson or CSA Coordinator in their areas (www.csa.state.va.us/index.cfm).

The FAPT team assesses the strengths and needs of the youth and families who are approved for referral to the team, develops **Individual Family Services Plans** that identify the services required to meet their unique needs, and makes recommendations to the CPMT for funding. If a family disagrees with the service plan that is developed, it may ask for a CPMT review; however, emergency services can proceed while this review is taking place. The FAPT, with the assistance of the family and the youth's case manager, is responsible for identifying providers for needed services. If a family's needs cannot be met by the participating agencies, and there are no other community resources available, the team may then use CSA pool funds to purchase services. Except where prohibited by state or federal law and regulations, parents may be required to make co-payments for services according to a standard sliding fee.

Effective July 1, 2009, all youth determined eligible for services through CSA must be evaluated using the **Child and Adolescent Needs and Strengths (CANS)** standardized assessment instrument. Youth already served through CSA on that date were evaluated with CANS at the time of their next regularly scheduled reassessment. Results of these assessments guide service planning for children and their families and enable tracking of progress on meaningful outcomes. They also improve identification of service gaps and promote resource development.

The requirement that some parents were required to relinquish custody of their children in order to receive services through CSA was identified as a key issue in previous editions of the assessment. In 2006, Virginia's Attorney General issued an advisory opinion (www.oag.state.va.us/OPINIONS/2006opns/05-095-Fralin.pdf) that foster care services, as defined by the *Code of Virginia* (63.2-905), include the full range of treatment services when a child is abused or neglected (63.2-100) or "in need of services" (16.1-228). The opinion further stated that constitutional and statutory provisions require that CSA services be provided to eligible children without requiring parents to relinquish custody and that the FAPT and courts, rather than just the courts, could make the determination that a child was "in need of services." This opinion

allowed families to seek mental health treatment for children with severe emotional or behavioral needs without going through the court system.

In SFY 2010, 369 children received services through CSA based on agreements between parents and agencies other than local social services departments designated by CMPTs. Under these “parental agreements,” the parents retained legal custody and the children were placed outside of the home for treatment of their emotional or behavioral needs. In many of these cases, FAPT determined the children to be “in need of services,” and in others, a court made the decision.

The following table shows the number of youth who received services under CSA for state fiscal years (SFYs) 2005, 2007, and 2010 by their source of referral.

YOUTH SERVED UNDER THE *COMPREHENSIVE SERVICES ACT* BY REFERRAL SOURCE

Referral Source	SFY 2005		SFY 2007		SFY 2010	
	#	%	#	%	#	%
Social Services	9,842	61%	11,735	63%	10,128	58%
Education	3,251	20%	3,790	20%	4,467	25%
Juvenile Justice	1,294	8%	1,322	7%	1,370	8%
Interagency Teams	1,027	6%	676	4%	226	1%
Community Services Boards	664	4%	662	4%	1,205	7%
Families	66	<1%	70	<1%	67	<1%
Health	2	<1%	6	<1%	8	<1%
Other Sources	101	1%	197	1%	97	<1%
Total	16,247	100%	18,458	100%	17,568	100%

Source: Office of Comprehensive Services (OCS) for At-Risk Youth and Families.

Historically, as shown above, most referrals to FAPT come from local social services departments and school divisions because youth in foster care or with special education needs are mandated populations for CSA. Collectively, these two sources accounted for more than 80 percent of referrals in SFYs 2005, 2007, and 2010, and while there was a decline of five percentage points in referrals by social services departments in SFY 2010, the number of referrals by school divisions increased by the same amount. During this time, referrals from the juvenile justice system, the next highest proportion, have remained stable. On the other hand, referrals from Community Services Boards (CSBs) have nearly doubled, from four to seven percent of the total, while referrals from interagency teams have declined from six to one percent of the total.

In total, the number of youth served under CSA rose by 13.6 percent from SFY 2005 to SFY 2007, then declined by 4.8 percent from SFY 2007 to SFY 2010. This decline is likely attributable to a number of factors, with the most significant being the Commonwealth’s interagency effort since 2007 to increase the number of youth receiving community-based services in their homes.

In 2008, the General Assembly approved the use of financial incentives for localities to reduce reliance on residential programs. Beginning January 1, 2009, to encourage the use of community-based rather than residential services, the required local matching payment rate for residential services was increased by 15 percent over the SFY 2007 base rate for amounts in excess of \$100,000 expended through June 2009 and by 25 percent for amounts exceeding \$200,000. A hold harmless provision was included to protect smaller localities that may experience one or two expensive residential placements in a year; however, due to budget challenges, the 2010 General Assembly eliminated this exemption for the first \$200,000 in residential services. This new rate structure enabled the state to obtain federal Title IV-E funds that can be used to provide greater assistance for foster and adoptive families, and effective October 2009, the legislature increased the Additional Daily Supervision (ADS) payment rate to foster and adoptive parents based on the increased supervision needs of children being served in the home rather than in residential programs.

During SFY 2008, 34 percent of all CSA services were provided in the community or in schools; 47 percent in family-like settings such as family foster homes and therapeutic foster homes; 17 percent in licensed residential settings such as intensive treatment services, group homes, or temporary shelter care; and less than one percent in psychiatric hospitals. In contrast, for SFY 2010, the percentage of CSA services provided in the community or schools grew to 42 percent, declined for family-like settings to 39 percent, increased slightly to 19 percent in licensed residential settings, and remained stable at less than one percent for psychiatric settings.

As noted in this chapter's introduction, OCS has worked closely with the Department of Social Services (DSS) to implement new **Children's Services System Transformation** practices outlining the values and principles directing agency interactions with families and service providers. In March 2010, the CSA State Executive Council approved policy guidance implementing a "**Family Engagement Model**" and CSA funds have been allocated for Family Partnership Meetings structured to involve and engage a child's extended family and natural supports into decision-making for children in foster care or at risk of foster care placement.

Supporting these OCS efforts, staff at local social services departments have been trained to use the **Virginia Enhanced Maintenance Tool (VEMAT)** to assess a child's needs and the level of supervision needed to maintain the child in a foster home. Therapeutic foster homes operated by private agencies currently use VEMAT, and its use will be extended to those operated by public agencies. At the state level, the Department of Medical Assistance Services (DMAS) is implementing a demonstration grant creating a new **Children's Mental Health Waiver** (http://dmasva.dmas.virginia.gov/Content_atchs/mch/mch-cmh1.pdf) to help children in psychiatric residential treatment facilities, who are eligible for Medicaid, receive community-based health services and family supports.

Independent Living and Related Services: The 15 **Centers for Independent Living (CILs)** and their four satellite operations spread across 18 of the state's 23 planning districts work directly with individuals with disabilities to identify needs, plan services, and assist with access to local services that will reduce barriers to independent living. Individuals needing assistance

should contact the CIL office in or closest to their locality (www.vadrs.org/cbs/cilslisting.htm) to access services. At the time of this assessment, CIL locations included Norfolk, Hampton, the Eastern Shore, Richmond, Fredericksburg, Arlington, Manassas, Charlottesville, Winchester, Roanoke, Lynchburg, Abingdon, Grundy, Harrisonburg, and Big Stone Gap. Satellite service locations included Petersburg, Christiansburg, Arlington, and Hampton. The CIL located in Danville discontinued its operations in the spring of 2011 as a result of audit and evaluation findings determined through the monitoring processes described later in this chapter.

CIL staff, a majority of which are required by federal statute to be individuals with disabilities, help an individual develop a plan for independent living services that takes into account the level of independence that the individual wishes to obtain. The plan records mutual agreements on what services will be provided and how and when they will be delivered. If requested by the individual with a disability, the plan must be in writing.

The number of individuals served and hours of service by CILs has fluctuated in recent years due to changes in annual goals and funding source priorities. Statewide, approximately 8,000 individuals were served in state fiscal year (SFY) 2005 and more than 7,200 in SFY 2007. Over 100,000 hours of service were provided to more than 9,400 individuals in SFY 2008, and in SFY 2010, more than 9,000 individuals received more than 80,000 hours of service.

Department for the Blind and Vision Impaired (DBVI) staff provide intake and make referrals for the agency's **Rehabilitation Teaching/Independent Living (RT/IL) Program** at six regional offices located in Bristol, Fairfax, Norfolk, Richmond, Roanoke, and Staunton. RT/IL staff work directly with individuals needing assistance to explain services, assist them in establishing eligibility, educate them on available resources, and refer them to appropriate DBVI programs or other community services. Orientation and mobility training, which has a direct impact on an individual's success in school, employment, and community living, is provided through the **DBVI Vocational Rehabilitation, Rehabilitation Teaching, and Education Services** program. For some service recipients, independent living and orientation-to-blindness skills training occurs at the **Virginia Rehabilitation Center for the Blind and Vision Impaired**. Individuals may also be referred to programs in other states when those programs can better meet their needs.

The number of individuals receiving orientation and mobility training decreased from 930 in state fiscal year (SFY) 2005 to 859 in SFY 2007 and 562 in SFY 2010, a total decline for the period of 39.6 percent. Most of this decline occurred between SFY 2007 and SFY 2010, a 34.6 percent drop, primarily due to DBVI's inability to fill vacancies for four of its 14 Orientation and Mobility Specialist positions because of lack of funding.

DBVI's **DeafBlind Services** program, which ensures that individuals with both vision and hearing impairments are full participants in all of its major programs, served 204 individuals in SFY 2005, 206 in SFY 2007, and 156 in SFY 2010. While the number served by this program was stable from SFY 2005 to SFY 2007, DBVI's recent inability to fill a vacancy for the program's director due to budget constraints resulted in 23.3 percent drop in the number served

over the entire period. During this time, DBVI's remaining DeafBlind Services specialist was able to provide services for individuals only in the western half of the state.

Individuals who cannot see with conventional glasses can obtain vision examinations and follow-up services from a statewide network of providers managed by DBVI's **Low Vision Services** program. As appropriate, those examiners refer individuals for follow-up assessments, counseling, and training. Training can occur in school, home, or other appropriate settings and includes the use of prescribed low vision optical aids. The DBVI Rehabilitation Teachers also provide case management to low vision customers being served through the Older Blind Grant Program. As above, budget constraints have had an impact on the number of individuals whom DBVI has been able to serve through this program, which dropped 22.6 percent from 1,200 in SFY 2005 to 929 in SFY 2007, then rose slightly by 2.6 percent to 953 in SFY 2010.

(Non-Waiver) Intellectual Disability Services: As noted previously, the **Department for Behavioral Health and Developmental Services (DBHDS)** is the state's designated administrative agency for intellectual disability services. For delivery of services, DBHDS contracts with local **Community Services Boards (CSBs)** that serve as the single point of entry into the state's mental health, intellectual disability, and substance abuse services system. CSBs are created by municipalities, for the most part, as independent authorities rather than as departments of city or county government. They are required to "provide individualized, effective, flexible, and efficient treatment, habilitation, and prevention services in the most accessible and integrated setting possible." Because each CSB is unique, reflecting its own community and available local resources and delivering its own mix of services directly or through contracts with numerous private providers, the availability of and eligibility for services varies widely among CSBs.

To receive services from a CSB, an individual is first "admitted" or "enrolled" and a medical record is opened in a face-to-face process. This admission is for services in general, not for any particular program, and by enrolling, the individual expresses his or her willingness and intention to receive services through the CSB. Next, an assessment of the individual's needs is made and eligibility for specific services addressing those needs is determined. Depending on specific needs, an **Individualized Services Plan (ISP)** or **Plan of Care (POC)** is developed that guides the implementation of needed services.

The table below shows the unduplicated number of individuals receiving core intellectual disability services for selected state fiscal years (SFYs) 2004 through 2009 from CSBs, as well as the amount and percentage of change from the previous year. As indicated, the total unduplicated number served increased from SFY 2004 to SFY 2006, by 12.4 percent for the entire period, with a significantly slower rate of growth in the second year. The number then dropped a total of 34.8 percent from SFY 2006 to SFY 2009 with most of that decrease occurring in the last year.

**PERSONS RECEIVING CORE INTELLECTUAL DISABILITY SERVICES
FROM COMMUNITY SERVICES BOARDS**

State Fiscal Year	Persons Served	Change	Percent
2004	23,925	----	----
2005	26,050	+2,125	+8.9%
2006	26,893	+843	+3.2%
2008	25,053	-1,840	-6.8%
2009	17,530	-7,523	-30.0%

Source: Department of Behavioral Health and Developmental Services (DBHDS), *Comprehensive State Plans* for 2006-2012, 2008-2014, and 2010-2016.

The DBHDS *Comprehensive State Plans*, from which the data above was drawn, also provide extensive information on waiting lists for services based on a point-in-time survey of CSBs regarding individuals who have sought any intellectual disability service and been assessed by their CSB as needing service. The results of these surveys, covering January to April each year and considered to be conservative estimates, appear in the table below featuring the unduplicated number of adults and children waiting for services during the 2005, 2007, and 2009 survey periods, by the length of time they have been waiting, plus the amount and percentage of change for the entire period. A majority of those on CSB waiting lists were receiving some type of service by their CSB, but need other additional or more intensive levels of services or supports. Data for 2010 will not be available until release of the next edition of the DBHDS *Comprehensive State Plan* in the fall of 2011.

**PERSONS WITH INTELLECTUAL DISABILITIES AWAITING SERVICES
FROM COMMUNITY SERVICES BOARDS**

Wait Time	2005	2007	2009	Change	Percent
Less than 1 month	190	199	57	-133	-70.0%
1 to 3 months	1,033	683	766	-267	-25.8%
4 to 12 months	962	905	1,048	+86	+8.9%
13 to 24 months	735	918	1,112	+377	+51.3%
25 to 36 months	583	768	709	+126	+21.6%
37 to 48 months	392	524	608	+216	+55.1%
49 to 60 months	400	417	500	+100	+25.0%
61 to 72 months	168	321	387	+219	+130.4%
73 or more months	711	1,229	1,209	+498	+70.0%
Not Reported	42	28	62	+20	+47.6%
Total	5,216	5,992	6,458	+1,242	+23.8%

Source: Department of Behavioral Health and Developmental Services (DBHDS), *Comprehensive State Plans* for 2006-2012, 2008-2014, and 2010-2016.

As indicated, both the number waiting for intellectual disability services from CSBs and the typical length of their waiting time increased from 2005 to 2009. While the number waiting for one year or less (29 percent of the total in 2009) decreased by 314 (a 14.4 percent reduction),

the number waiting one to five years (45 percent of the total) increased by 819 (38.8 percent) and for more than five years (25 percent of the total) by 717 (plus 81.6 percent).

Based on these survey results, the DBHDS *Comprehensive State Plan* for 2010-2016 reports that the following services were most often needed by both children and adults with intellectual disabilities who had been on the waiting list for more than 48 months:

- Supportive services including supportive living, in-home, personal assistance, and companion services;
- Case management; and
- Residential services including supervised residential and intensive (congregate) services.

The surveys also identify the number of children and adults with intellectual disabilities who are not receiving any CSB services, an additional measure of the unmet need for services. In 2005, there were 938 individuals who were not receiving any services. This count increased to 1,114 in 2007 and to 1,342 in 2009, an increase for the entire period of 43.1 percent, or 404 individuals.

Interpreter Services and Related Programs for the Deaf and Hard of Hearing: The state **Department for the Deaf and Hard of Hearing (DDHH)** coordinates requests for qualified interpreters for persons with hearing or speech impairments from individuals, state courts, state agencies and institutions of higher education, local government agencies and legislative bodies, and other public and private organizations across the state. In state fiscal year (SFY) 2010, the **DDHH Interpreter Services Program** contracted with 60 state agencies and institutions of higher education to directly coordinate their needs through referrals to 64 contracted sign-language interpreters. Agencies needing services provide DDHH with the name of the individual to be served (if known), the nature of the assignment, and their billing information. Individuals needing interpreter services to conduct certain Department of Motor Vehicle (DMV) business transactions or to attend 12-Step meetings or funerals may also contact DDHH directly for assistance, with the latter two services provided at no cost.

For others needing assistance, DDHH compiles and provides a statewide *Directory of Qualified Interpreters and Interpretive Services Coordination* containing contact information for only those interpreters who meet state “Qualified Interpreter” requirements. Generally, these interpreters act as individual contractors, with those employing them responsible for their fees and expenses to provide interpretive services at a specific place and time for a predetermined number of hours. When an individual has been denied interpreter services by private providers or others covered by the *Americans with Disabilities Act (ADA)*, DDHH can provide fact sheets on effective communications that the individual can share with the provider. It also encourages the individual to have the provider contact them directly for additional information and assistance in locating a private interpreter.

DDHH coordinated 2,672 requests for interpreter services from state and local agencies and state courts in SFY 2007. In SFY 2010, it received more than 2,258 requests, of which it

was able to meet 99.65 percent. More specific comparison of requests between state fiscal years is not possible because of changes made in SFY 2010 to how requests are processed and counted. In the past, multi-date assignments were counted as separate requests; however, they are now processed as a single request.

Omnibus Budget Reconciliation Act (OBRA) Services: The Departments of Medical Assistance Services (DMAS), Rehabilitative Services (DRS), and the Behavioral Health and Developmental Services (DBHDS) collaborate in implementing the provisions of this statute, and its evaluation, self-determination, discharge planning, and service provision requirements for states were covered in the earlier section of this chapter on eligibility. Once an individual qualifies for OBRA services, DBHDS is administratively responsible for contracting with DRS and local Community Services Boards (CSBs) for distribution of the funds covering those services. DRS Community Rehabilitation Case Management (CRCM) Services staff operating out of DRS field offices or CSBs provide or coordinate services, and for individuals wishing to transition from an institution to a community setting, DRS Community Rehabilitation Specialists work with social workers, Centers for Independent Living (CILs), and other resources to ensure that they receive services appropriate to their choices about where they will live and how their needs can best be met. These decisions are usually influenced by the availability of housing and community supports available through Medicaid Home and Community Based Services (HCBS) Waivers or other sources. In most cases, support coordination may be continued by a Community Rehabilitation Specialist if an individual is not receiving case management through a Medicaid HCBS Waiver or other program; however, OBRA funding for that support does not extend beyond the one-year transition period.

The number of individuals assessed by DBHDS and receiving services by DRS under OBRA in selected state fiscal years (SFYs) between 2005 and 2010 and the amount and percentage change for the entire period are shown below. DBHDS data originally reported in the 2008 edition of this assessment has been revised in this edition.

**INDIVIDUALS ASSESSED OR SERVED
UNDER THE *OMNIBUS BUDGET RECONCILIATION ACT***

Agency	SFY 2005	SFY 2007	SFY 2010	Change	Percent
Assessed by DBHDS	350	390	395	+45	+12.9%
Served by DRS	224	188	127	-97	-43.3%

Sources: Department of Rehabilitative Services (DRS) and Department of Behavioral Health and Developmental Services (DBHDS), respectively.

While the number assessed by DBHDS under OBRA increased between SFY 2005 and SFY 2010 by 12.9 percent, the number receiving services by DRS declined for the same period by 43.3 percent. Rates of change were also in contrast, with a greater increase in DBHDS assessments prior to SFY 2007 (11.4 percent versus 1.3 percent) and a greater decline in those receiving services by DRS after SFY 2007 (16.1 percent before versus 32.4 percent after).

(Non-Waiver) Personal Assistance Services (PAS): Regardless of their source or funding, personal assistance services facilitate community inclusion and greater independence for individuals with disabilities who require assistance with certain nonmedical physical and personal needs. Individuals receiving **State-Funded PAS** or **PAS for Individuals with Brain Injury (PAS/BI)** from the Department of Rehabilitative Services (DRS) have a direct employer-employee relationship with their personal attendants (PAs). As with consumer-directed PAS offered through the Medicaid Home and Community Based Services (HCBS) Waivers described in an earlier chapter of this assessment, the person with a disability or someone assisting them recruits and hires a PA, provides training, establishes work schedules and duties, directs the PA's work, authorizes timesheets for payment, and terminates the PA if necessary. To learn more about handling these responsibilities effectively, the individual with a disability must participate in PAS orientation training.

DRS staff review PAS applications, conduct initial eligibility screenings, and authorize related activities by the Centers for Independent Living (CILs) which are responsible for conducting needs assessments, orientation for persons with disabilities, and reassessments as well as providing other support services. DRS also reviews PA hiring packets for completeness and accuracy, calculates and approves the number of PAS hours that the individual may receive, and determines final eligibility. Following DRS review and approval of timesheets, verification of employment and earnings, and payroll preparation, a contract payroll provider handles payments, taxes, and earnings reports. As noted earlier, **Vocational Rehabilitation PAS (VR-PAS)** provided as necessary by DRS and the Department for the Blind and Vision-Impaired (DBVI), which may be either consumer- or agency-directed, is covered in the Employment chapter of this assessment.

The following table summarizes the number of persons receiving or on the waiting list for PAS provided by DRS for state fiscal years (SFYs) 2005, 2007, and 2010.

PERSONAL ASSISTANCE SERVICES (PAS) PROVIDED BY DRS

PAS Program	SFY 2005		SFY 2007		SFY 2010	
	Served	Waiting	Served	Waiting	Served	Waiting
State-Funded PAS	166	53	166	54	122	94
PAS/BI	8	7	6	2	5	3
VR-PAS	46	N/A	62	N/A	45	N/A

Source: Department of Rehabilitative Services (DRS).

Over this time period, the number of individuals served by all three DRS PAS programs has declined; although the number rose temporarily for VR-PAS in SFY 2007 before returning to approximately the same number in SFY 2010 as in SFY 2005. Both the number served and on the waiting list for PAS/BI are relatively small and thus subject to fluctuation, and there is no waiting list applicable ("N/A") for VR-PAS. For the years shown, the combined number served and on the waiting list (219, 220, and 216, respectively) for State-Funded PAS reflected an essentially unchanged need for these services. As a result, when the number served by State-

Funded PAS dropped by 26.2 percent from SFY 2007 to SFY 2010, the number on the waiting list rose by 74.1 percent, after having been stable from SFY 2005 to SFY 2007.

Services for the Elderly Population: The **Virginia Department for the Aging (VDA)** is responsible for coordination, technical support, and oversight of independent local **Area Agencies on Aging (AAAs)** and other contractual partners that deliver services for Virginians who are ages 60 and over or have disabilities and their families. VDA ensures that services are available statewide, develops and monitors service quality standards, and as both an educational and outreach resource, acts as a central referral agency for direct services provided by the 25 AAAs and 20 other community-based organizations.

AAAs typically receive requests for information or services by phone, then follow-up with person-to-person assessments as indicated. In areas where **No Wrong Door** aging and disability resource connections, described in more detail below, have been established among service agencies, AAAs can enter an applicant's information into a shared electronic database to expedite their receipt of services and coordination of their providers. While many AAA services, such as information and referral, are offered free of charge, some in-home and other services are provided on a sliding fee scale based on ability to pay.

Collectively, VDA, the AAAs, and their contracted partners provided services for 59,126 individuals in state fiscal year (SFY) 2005, to 58,873 in SFY 2006, to 58,241 in SFY 2007, and to 58,045 in SFY 2009. Waiting lists are maintained by some local programs where the number of requests for services exceeds the number that they are contracted to serve.

The **Public Guardianship Program** is one of the services administered by VDA through contracts with local agencies. Initial identification of individuals needing assistance, regardless of age, is made by local adult care facilities, the Adult Protective Services divisions of local social services departments, hospitals, and other organizations that serve persons who are indigent and may be incapacitated. They forward relevant information to a multi-disciplinary panel of the local guardianship program that determines whether it can best provide guardianship services. If so, the referring agency, either independently or with the assistance of a city or county attorney or volunteer counsel, requests a guardianship or conservatorship hearing by the Circuit Court. The judge may require specialized evaluations of the individual to obtain additional medical, psychiatric, psychological, or social information.

If the court finds the person to be incapacitated and in need of a guardian or conservator, the judge has flexibility in establishing the type of guardianship or conservatorship to preserve as much of the individual's independence as possible. They may be established on an emergency or temporary basis, applicable for a limited time or to decisions that correct conditions causing the emergency, or they may be limited to situations when decisions are needed about specific issues, such as health care or certain monetary matters. A standby guardian can also be designated who will assume the role after the death of the person currently responsible for care of another. Other legal alternatives to guardianship and conservatorship that can be exercised in Virginia include power of attorney, advanced medical directives (commonly called "living wills"), representative

payees, and various types of trusts. The details of these alternatives are beyond the scope of this assessment, and appropriate legal and administrative authorities should be consulted for more information.

After approval by the court, the local guardianship program takes responsibility for the incapacitated person and acts on his or her behalf consistent with the specific tenets of the guardianship. An individual may petition the court at a later date to end the guardianship, and a judge may terminate the guardianship if the individual is able to show that he or she can care for and manage his or her own affairs. In some circumstances, the judge may appoint another person or entity to be guardian or conservator.

Based on available funds, VDA designates a maximum number of individuals who can be served annually by each local guardianship program. Local programs do not exist in all areas of Virginia, and in 2010, all local programs were at capacity and some now have waiting lists. At the end of SFY 2010, the state's 15 local guardianship programs had a total capacity to serve 601 individuals, of which 249 slots were limited to individuals served through the state Department of Behavioral Health and Developmental Services (DBHDS). This number has been stable after a period of growth, with 212 served in SFY 2005, 580 in SFY 2007, and 601 in SFY 2009.

Due to state budget cuts, 18 guardianship slots were eliminated in state fiscal year (SFY) 2010, and in SFY 2012, additional slots are expected to be eliminated. According to VDA, reductions in available guardianship slots mostly impact individuals who reside in institutions and are ready for transition to a community setting, but need a public guardian in order to make the transition. A 2007 study by the Virginia Tech Center for Gerontology, the most recent analysis available, estimated that 1,441 persons statewide were indigent and incapacitated in SFY 2008 and had no one willing to act as a guardian (also referred to as a substitute decision-maker). The study projected that the number needing public guardianship services would reach 1,707 in SFY 2010.

The statewide **No Wrong Door** initiative has already been mentioned above and in several other places in this assessment. To improve access to services and technical assistance for both older adults and individuals with disabilities and their families, VDA has prioritized development and expansion of local aging and disability resource connections, led by AAAs, that create an internet-based, virtual "single point of entry" for accessing services. Between SFYs 2006 and 2008, VDA contracted with ten AAAs for pilot No Wrong Door projects, and during SFYs 2009 and 2010 an additional five AAAs became involved. Integration of the remaining ten AAAs over the next year will complete statewide coverage.

These local No Wrong Door networks of public and private agencies connect to a statewide database and eliminate the need for individuals and their families to contact multiple providers or complete duplicative forms, reducing their frustration and long waits to obtain needed services. This evolving model relies heavily on interagency cooperation and coordination among Centers for Independent Living (CILs), Community Services Boards (CSBs), social services and health departments, and other public and private service providers.

A uniform statewide technology platform enables these providers to share up-to-date client information, streamline eligibility determinations, make referrals between agencies more easily, better coordinate services, and track outcomes. Statewide oversight establishes the protocols needed to ensure that providers' and their clients' privacy is protected and that information is shared with their consent.

At the individual level, No Wrong Door puts information and tools directly in the hands of consumers through its interactive online portal, **Virginia Easy Access**. This website and its support network, described in more detail in the Information and Advocacy appendix to this assessment, were created through a public-private partnership of the Commonwealth of Virginia, SeniorNavigator, and 2-1-1 Virginia. Virginia Easy Access is a self-directed way for individuals to obtain information about the community options available to best match their long-term care needs. Unfortunately, as some citizens including members of the General Assembly have noted, this relatively new system still has user-friendliness and reliability issues, and the information that it contains is not comprehensive. For example, it lacks information and resources specifically addressing long-term care needs for children. To help address user-friendliness issues, especially for individuals who do not have a computer or internet access or who need assistance in accessing Virginia Easy Access online, **VirginiaNavigator Centers** are being established. There are currently over 200 centers across the state in partnership with local libraries, community centers, faith-based organizations, and other agencies that serve as information and referral resources.

VDA is also responsible for administering the **Community Living Program**, similar to the Program of All-Inclusive Care for the Elderly (PACE) described below, that helps aging individuals at risk of nursing home placement remain in their homes and communities. Ten AAAs are involved in this program, conducting extensive outreach for participants through various local service providers, advocacy groups, professional organizations, and community events. Individuals enrolled in the program or their caregivers will be asked by their AAA to participate in a survey interview regarding the impact of using self-directed services. The Virginia Tech Center for Gerontology, which is serving as external evaluator for the program, will report on the survey's results. From September 2009 through September 2011, the Community Living Program provided up to \$1,200 per person, per month of consumer-directed services for 95 older Virginians.

To obtain information or services from the **Older Blind Grant Program** administered by the **Department for the Blind and Vision Impaired (DBVI)**, older Virginians can contact any one of the agency's regional offices mentioned earlier or call its toll-free number, 800-622-2155. Staff at those locations can explain available services, assist in establishing eligibility, and make referrals to specific DBVI programs or other community resources as appropriate. Funds from this program supported services for 2,306 individuals in state fiscal year (SFY) 2005, for 2,178 in SFY 2007, and for 1,602 in SFY 2010. Over this period, the number served declined by a total of 30.5 percent. Following a small decline of 5.6 percent from SFY 2005 to SFY 2007, DBVI reports that an increase in the number of private practices serving individuals with low

vision reduced the number of referrals to the Older Blind Grant Program and contributed to the much larger drop of 26.4 percent between SFY 2007 and SFY 2010. DBVI is currently working on strategies to better inform optometrists, ophthalmologists, and other eye-care professionals of the array of services available through this program.

The **Program of All-Inclusive Care for the Elderly (PACE)** enables individuals ages 55 and over to “age in place.” Services are provided by designated agencies contracted by the **Department of Medical Assistance Services (DMAS)**. Prior to implementation of new PACE services in a locality, DMAS offers training on the program to all screeners and hospitals in the covered area, who then work with DMAS to identify all eligible individuals in that area and offer them PACE services. PACE coverage has gradually expanded since November 2007 and now includes seven operations in various areas of the state. Three additional locations are planned for Northern Virginia, Roanoke, and Charlottesville. Existing operations at the time of this assessment were:

- Sentara Senior Community Care (SSCC) serving individuals in the Hampton Roads area;
- Riverside at the Peninsula serving Newport News, Poquoson, the southeastern part of York County, and other parts of Hampton Roads;
- Mountain Empire PACE in Big Stone Gap serving the counties of Lee, Norton, Wise and Scott;
- AllCare for Seniors PACE in Cedar Bluff serving the counties of Tazewell, Buchanan, Dickerson and Russell;
- Riverside PACE in Richmond serving that city, portions of Petersburg and Henrico County, and the counties of Chesterfield, Goochland, Powhatan, New Kent, and Hanover;
- Centra Health PACE in Lynchburg serving that city and the counties of Bedford, Campbell, Nelson, Appomattox and Amherst.

As PACE coverage has expanded, so has the number of individuals served by the program, from 123 statewide in state fiscal year (SFY) 2007 to 626 in SFY 2010, with an average annual cost for PACE services in that year of \$25,620 per person. DMAS has identified elderly individuals with a documented diagnosis of intellectual disability (ID) as a growing subpopulation of PACE clients, 36.3 percent of the 509 receiving services as of June 1, 2010. Of the total of 185 individuals with ID served statewide on that date, 92 (49.7 percent) were served by PACE operations in the Tidewater area (Hampton, Virginia Beach, and Portsmouth).

D. Available Community Supports

As noted in the introduction to this chapter, it would be impossible to cover all of the available community supports in this assessment. The programs and services described below are subject to the eligibility and access procedures described in the preceding sections, and additional services not described below may be available from these agencies.

Assistive Technology (AT) and Related Services: Available AT devices, services, and funding sources vary among the **Department of Rehabilitative Services' (DRS) Virginia Assistive Technology System (VATS)** regional sites but generally include AT loans, training and demonstrations, information and technical assistance, and public awareness outreach. To help individuals make informed decisions about the use of AT, staff at the sites can provide more detailed guidance the application and benefits of specific devices and services, including what gently used, donated equipment may be available through **Virginia Reuse Network (VRN)** recycling programs coordinated by VATS.

The outpatient clinics and outpatient programs at DRS' **Woodrow Wilson Rehabilitation Center (WWRC)** provide a variety of AT services for adolescents and adults with disabilities who desire employment, including specialized and individualized computer technology, vehicle modification recommendations, customized rehabilitation engineering and fabrication, augmentative or alternative communication, customized seating systems and mobility enhancement, assistive listening devices, and adaptive devices for daily living and recreation. WWRC also provides the specialized training in AT use critical to successful integration of assistive technology into an individual's daily functioning. For example, its ten-day, intensive, residential Empowerment through Communication (ETC) program assists individuals in improving their communicative competence using alternative/augmentative communications (AAC) devices.

The **Department for the Deaf and Hard of Hearing's (DDHH) Technology Assistance Program (TAP) Loan-to-Own (L2O)** program provides information, referral, and technical assistance services and distributes TTYs, captioning telephones, amplified phones and handheld devices, signalers, speech amplifiers, and specially requested equipment for persons with both a hearing and vision loss. Services of DDHH's free **Virginia Relay** system that provides individuals who are hearing or speech impaired with assistance in using a telephone was described in earlier sections of this chapter.

The Assistive Technology Loan Fund Authority's **NewWell Fund** low-interest loans to individuals can be used for vocational and recreational equipment, hearing aids, specialized computer software, home or vehicle modifications, or any other personal AT equipment and associated training as long as it relates to the person's disability. Loans for home-based businesses are limited to business-related equipment, inventory, or supplies. The NewWell Fund can also arrange for and fund consumer counseling for loan applicants who need application assistance and for assessments related to obtaining AT equipment when alternative funding sources are not available.

Brain Injury (BI) and Spinal Cord Injury (SCI) Services: The **Department of Rehabilitative Services' (DRS) Brain Injury Services Coordination (BISC) Unit** contracts with nine regional providers for case management services, "clubhouse" day programs, and regional resource coordination. The BISC Unit, itself, assists DRS offices in resolving consumer concerns and provides support and technical assistance to other DRS and community-based brain injury services programs through direct training for vocational rehabilitation field staff and

community partners and sponsorship of their attendance at specialized training conferences and workshops.

The **Brain Injury Direct Services (BIDS) Fund** administered by DRS pays for short-term services for a small number of eligible individuals with acquired brain injury each year. These services are typically provided on an outpatient basis in community settings, cannot be funded by other means, and include neuropsychological assessment and counseling; neurobehavioral assessment and intervention; medical, speech, physical, occupational, cognitive, and other rehabilitation therapies; assistive technology (AT) assessments, purchases of recommended AT equipment, such as wheelchairs and communications devices, and related training or services; and community support services such as life skills training. Assistance in transitioning to other community supports and training for employers and family members are provided as appropriate. Because of limited resources, the BIDS Fund does not pay for either residential services or inpatient medical rehabilitation services.

The DRS **Woodrow Wilson Rehabilitation Center's (WWRC) Brain Injury Services Department** and **Spinal Cord Injury Services** program engage in outreach to individuals with these disabilities and provide direct services for them. Services are similar for both programs and involve both the individual who has sustained the brain or spinal cord injury and his or her family when appropriate. Intervention, assessments, treatment planning, and service delivery by interdisciplinary teams comprised of staff at WWRC and partners from the community emphasize self-sufficiency, responsibility for managing personal and physical needs, and vocational preparation. Assessments include home and work accessibility, assistive technology needs, and independent living skills, as well as driving, vocational, and other evaluations, as indicated. Available therapies include occupational, physical, psychological, neuropsychological, speech/language, life skills, and cognitive. Rehabilitation nursing, dietary, pharmacy, radiology, laboratory, and other health care services; opportunities to interact with peers at various levels of rehabilitation; and chaplain services are also available. Both programs include referral to the **WWRC Life Skills Transition Program**, a comprehensive, on- and off-campus educational opportunity to develop interpersonal, independent living, pre-employment, and leisure skills and basic workplace literacy.

In the past, all of the services described above have been provided by WWRC on both a residential and outpatient basis; however, in April 2011, WWRC announced that certain outpatient services were being phased out over the next three months due to budget pressures. Plans include elimination of 13 positions providing medical services as well as physical, occupational, and speech/language therapies. Radiology and laboratory services will be outsourced. To allow WWRC staff to focus on individuals with disabilities who are in need of vocational rehabilitation services, current outpatient clients who are not involved in vocational rehabilitation will be referred to community providers for medical and related services.

Community Rehabilitation Case Management (CRCM) Services: As previously noted, CRCM specialists work collaboratively with eligible individuals, including those residing in nursing homes, to plan services and supports in the community that will enhance their quality of

life, independence, and if applicable, employment. By providing information, referrals, and support coordination, they link these individuals to assistive technology, support groups, medical care, social and recreation opportunities, housing, transportation, counseling, and other services and supports appropriate to their needs. The CRCM Services program also provides support coordination under the Medicaid Home and Community Based Services (HCBS) Individual and Family Developmental (DD) Waiver which is described in detail in the Medicaid chapter of this assessment.

Comprehensive Services Act (CSA): The **Family Assessment and Planning (FAPT) Teams** described earlier are responsible for identifying, planning, and coordinating services for CSA-eligible youth. No specific menu of services exists because services are tailored to the unique needs of each child and his or her family. Within statutory and policy guidelines, a full range of services is possible, including comprehensive assessments, crisis stabilization and intervention, behavioral aides, respite care, mentoring, mental health services, substance abuse services, intensive in-home services, specialized “wrap-around” services, therapeutic day treatment, afterschool services, vocational services, independent living services, special education private day programs, or residential care. Eligible youth, a large proportion of whom have mental health challenges, generally receive more than one of these services during the year, and the most frequently used in state fiscal year (SFY) 2010 were community-based services such as mentoring, intensive in-home services, intensive care coordination, out-patient therapy, parent education and skills training, and therapeutic foster care.

Independent Living and Related Services: Helping individuals develop personal and systems change advocacy skills is a fundamental part of the independent living mission, and as the primary resource for community living supports in Virginia, **Centers for Independent Living (CILs)** are required to provide certain core services including information and referral, peer counseling, advocacy, and independent living skills training. Most CILs provide additional services beyond their core responsibilities, such as linkages to housing resources, and to improve and expand employment opportunities for people with significant disabilities, they inform and advise local, state, and federal legislators and administrators, are involved in community planning and decision-making, and work with local governments and employers. Some CILs provide peer counseling as well as mentoring and skills training programs in schools, and many hold recreational events that bring together local residents with and without disabilities.

The **Department for the Blind and Vision Impaired’s (DBVI) Rehabilitation Teaching/Independent Living (RT/IL) Program** provides individualized needs assessments, adjustment counseling, information and referrals, and skills training through a variety of programs described earlier, including the **Rehabilitation Center for the Blind, Low Vision Services, and DeafBlind Services**. DBVI rehabilitation teachers are located across the state and generally provide these services in the individual’s home. They also educate family members and others who wish to be of assistance to an individual with vision impairment. Skills training programs cover self-advocacy and outreach, daily living and home management, and forms of communication including Braille. Assistive technology, rehabilitation engineering, and other

specialized services are provided as well, including visual examinations, optical aids, and follow-up services for persons who cannot see with conventional glasses that are offered through the Low Vision program. DBVI Orientation and Mobility training teaches the use of the long cane as a travel tool as well as specific techniques to allow individuals with vision impairment to establish and maintain orientation to their surroundings. DeafBlind Services provides additional specialized services, particularly in the area of communication, and provides guidance and technical assistance to other DBVI programs, other public and private organizations, and the general public regarding the unique needs of its target population.

(Non-Waiver) Intellectual Disability Services: As the Commonwealth's single point of entry for intellectual disability services, local **Community Services Boards (CSBs)** can provide eight categories of "core" services either directly or through contracts with other public or private service providers. CSBs are mandated to provide only emergency services and, subject to available appropriations, case management services. The other core services that CSBs may choose to offer include outpatient, residential, prevention, early intervention, employment, and day support services. As further described in the Community Housing chapter of this assessment, individual CSBs may provide various levels of residential services described as supportive, supervised, intensive, and highly intensive. Some CSBs also offer family support services such as behavior management and respite care.

Interpreter Services and Related Programs for the Deaf and Hard of Hearing: The **Virginia Department for the Deaf and Hard of Hearing (DDHH)** directly coordinates requests for qualified interpreters by state agencies, courts, and certain others as specified earlier in this chapter. It also compiles and distributes a *Directory of Qualified Interpreters and Interpreter Services Coordination* for use by any individuals and organizations statewide to identify and arrange interpreter services. DDHH's outreach program provides information and training for individuals and civic organizations on topics including improving sign language skills, using interpreters effectively, obtaining assistive technology, and coping with hearing loss.

Omnibus Budget Reconciliation Act (OBRA) Services: The services most commonly requested and used by individuals covered under OBRA who reside in nursing facilities or who are transitioning from nursing facilities to community settings have been support coordination (case management) and day support for socialization, communication, and community integration. They generally also receive personal assistance services along with other services as needed and appropriate. Those additional services may include crisis intervention; psychotherapy; individual and group counseling; training in behavior management, communication skills, independent living, and utilization of community resources; educational assistance, prevocational training, and supported employment; assistive technology and rehabilitation engineering; and transportation to and from service providers. OBRA also provides transition services for individuals moving from a nursing home to the community that are not covered under other entitlements but are necessary to ensure a smooth transition, such as needed home modifications, deposits for utilities, and assistive technology.

Services for the Elderly Population: The 25 Area Agencies on Aging (AAAs) collaborate closely with their local health and social services departments, nonprofit organizations, and other resources, resulting in service offerings that are unique and diverse. Services typically include adult day care; programs that check on individuals in their own homes to ensure that they are safe and well; meal programs and nutrition services; health and wellness information and screenings; chore, homemaker, and personal care services; home modification and repair; care coordination; insurance counseling; elder-abuse prevention; money management and counseling; and legal assistance. General information, referral, and ombudsman services are provided as well, along with education, recreation, social, and volunteer opportunities. Some AAAs also offer employment, home heating and cooling, and tax filing assistance; transportation to and from activity centers or other programs; and help in completing applications for services from other sources. A few AAAs administer housing programs for older residents and run Program of All-Inclusive Care for the Elderly (PACE) centers.

The Virginia Department for the Aging (VDA) contracts with the AAAs to provide the following specific programs:

- Employment services for low-income older adults through the **Community Service Employment Program**,
- Benefits counseling for Medicare beneficiaries and others through the **Virginia Insurance Counseling and Assistance Program (VICAP)**,
- The **Virginia Public Guardianship Program** discussed in detail throughout this chapter, and
- **Virginia GrandDriver**, a resource for older drivers and their families or caregivers.

In addition to these contracted services, the VDA **Community Living Program** provides eligible participants with a monthly allotment to purchase needed supports such as assistive technology, a Personal Emergency response system, disposable medical supplies, transportation, personal care, homemaker services, home modifications, and nutritional supplements. Participants can also save up to \$5,000 from these allotments for the purchase of more expensive items or services, such as installation of a ramp for their home.

The **Department for the Blind and Vision Impaired's (DBVI) Older Blind Grant Program** offers a wide variety of services as well, including outreach; information and referral; advocacy; visual screening; eyeglasses and low vision aids; assistance with housing relocation; adaptive equipment to assist older blind Virginians to become more mobile and more self-sufficient; guide services for essential access to community resources; transportation; orientation and mobility services; peer counseling; volunteer reader services; adaptive skills training to assist in coping with daily living activities; and other essential supportive services for independent functioning in the home and community, including local independent living training workshops for consumers and their family members.

Using funds from the federal *American Recovery and Reinvestment Act* (ARRA), the Older Blind Grant Program began an initiative in June 2009 to provide visually eligible, computer literate older Virginians with accessible desktop computer systems and training in their use. With these systems, older individuals who are blind or vision impaired are once again able to independently access information and can communicate more effectively with others. The initiative is scheduled to continue until the federal “stimulus” funds are depleted or no later than September 30, 2011. As of January 2011, over 100 computers with appropriate assistive technology had been purchased for eligible recipients.

Each of the **Program of All-Inclusive Care for the Elderly (PACE)** sites listed in the previous section of this chapter provides the full scope of services under the Medicaid State Plan, which is described in the Medicaid chapter of this assessment. Each PACE participant receives a comprehensive assessment and treatment planning from an interdisciplinary team of professionals, all of whom have at least one year of paid experience working with the target population. The team also provides each enrollee with case management for all services provided or arranged by the PACE program.

E. Cost and Payment for Community Supports

Because of the number and complexity of agencies and initiatives that contribute to Virginia’s community supports system, a comprehensive discussion of specific allocation and payment mechanisms for every program is not feasible in this assessment. Extensive information about funding of state agency programs, however, can be found in the state appropriations bill and other documents available through the Department of Planning and Budget’s (DPB) website (www.dpb.virginia.gov) as well as in agency strategic plans posted to the Virginia Performs website (www.vaperforms.virginia.gov).

The table below contains data obtained from a variety of sources for state fiscal year (SFY) 2010 for many of the programs described in this chapter, and while limited, it can be helpful in understanding the range and levels of expenditures for community supports. Some programs were unable to respond to data requests in time for their information to be included in this assessment. When appropriate and possible, the number of individuals served and on waiting lists for services have been included. Notes follow the table clarifying certain details. Except as noted, Average Cost represents per capita cost, the total cost divided by the number served. “Not Applicable” (abbreviated as “N/A”) is indicated under Average Cost when expenditures by an agency or program cover multiple types of services for multiple individuals and cannot be determined on an average cost per person basis. Except as indicated in the notes, “Not Available” refers to situations where financial data was available for only the federal fiscal year (FFY) rather than the state fiscal year (SFY) or where a program was part of a larger initiative and the amount or designation of its funding and expenditures could not be separately determined.

SFY 2010 VIRGINIA EXPENDITURES FOR COMMUNITY SUPPORTS

Program or Service	Number Served	On Waiting List	State Funds	Federal Funds	Other Funds	Total Cost	Average Cost
Assistive Technology (AT) and Related Services^A							
NewWell Fund ^B	116	0	\$0	\$674,287	\$613,477	\$1,287,764	N/A
DDHH Technical Assistance Program (TAP) ^C							
Virginia Relay ^D	1,647,424	0	\$0	\$0	\$10,226,176	\$10,226,176	\$6
Virginia Assistive Technology System (VATS)							
	4,845	0	\$0	\$481,673	\$229,020	\$710,693	\$147
Brain Injury (BI) and Spinal Cord Injury (SCI) Services							
Brain Injury Direct Services (BIDS) Fund							
	15	6	\$18,135	\$0	\$0	\$18,135	\$1,209
DRS Brain Injury Services (approx.) Program Contracts ^E							
	11,800	100	\$3,821,000	\$0	\$0	\$3,821,000	\$324
WWRC BI Services ^F							
	132	14			Not Available		
WWRC SCI Services ^G							
	227	No List			Not Available		
Community Rehabilitation Case Management (CRCM) Services							
DRS CRCM ^H							
	708	79	\$507,643	\$0	\$0	\$507,643	N/A
Comprehensive Services Act (CSA)^I							
Mandated							
	16,193	No List	\$226,540,026	\$0	\$113,253,023	\$339,793,049	\$20,984
Non-Mandated ^J							
	1,375	Not	\$4,674,447	\$0	\$2,336,873	\$7,011,320	\$5,099
All CSA Services ^I							
	17,568	Available	\$231,214,473	\$0	\$115,589,896	\$346,804,369	\$19,741
Independent Living and Related Services							
Centers for Independent Living ^K							
	>9,000	No List	\$4,577,519	\$3,987,878	\$0	\$8,565,397	N/A
DBVI Rehabilitation Teaching/Independent Living (RT/IL) and Orientation and Mobility Services ^{L,M}							
	2,864	No List	\$1,672,535	\$1,762,156	\$85,000	\$3,519,691	N/A
DBVI DeafBlind Services ^L							
	156	No List	\$112,256	\$28,064	\$0	\$140,320	N/A
DBVI Low Vision Services ^L							
	953	No List	\$151,375	\$0	\$355,000	\$506,175	N/A
(Non-Waiver) Intellectual Disability Services							
Community Services Boards (CSBs) ^N							
	11,598	No List			Not Available	\$117,563,717	\$10,137
(Non-Waiver) Personal Assistance Services (PAS)							
DRS Brain Injury PAS							
	5	3	\$77,659	\$0	\$0	\$77,659	N/A
DRS State-Funded PAS							
	122	94	\$2,276,131	\$0	\$0	\$2,276,131	N/A
DRS Vocational Rehabilitation PAS							
	45	No List	\$0	\$511,417	\$0	\$511,417	N/A
Omnibus Budget Reconciliation Act (OBRA)							
	127	0			Not Available		
Services for the Elderly Population^O							
DBVI Older Blind Grant Program ^{L,P}							
	1,602	No List			Not Available		
Program of All-Inclusive Care for the Elderly (PACE)							
	626	No List	\$6,160,268	\$9,877,921	\$0	\$16,038,189	\$25,620

- A. No specific funding allocation is designated for assistive technology (AT) services at the **Department of Rehabilitation Services' (DRS) Woodrow Wilson Rehabilitation Center (WWRC)**. Services are provided on a fee-for-service basis and are reimbursed by Medicaid, Medicare, DRS, and other sources. Therefore, no data for this program has been included in this table.
- B. Funding for the **NewWell Fund's** loan program comes from a combination of sources, including federal grants, state appropriations, and matching public and private contributions. The amount listed under other funds reflects loans made directly by SunTrust Bank. Average loan amount per person was \$11,101 in SFY 2010.
- C. The number served by the **Department for the Deaf and Hard of Hearing's (DDHH) Technical Assistance Program (TAP)** includes both persons receiving equipment and those receiving technical assistance. TAP costs include loaned equipment, equipment demonstrations, and information and referral services.
- D. The number served for **DDHH's Virginia Relay** program reflects the number of completed calls rather than individuals. Average cost is per call, not per person.
- E. There are two categories of **DRS Brain Injury Services Coordination (BISC) Unit** contract services: direct brain injury services for individuals, which served 3,000 individuals, and outreach, which served 8,800 individuals through public awareness, public information, and referral services. In addition to the amounts shown here, DRS brain injury services programs brought in \$2,021,100 in non-state resources during SFY 2010, including grants, donations, volunteer services, and donated equipment and other goods.
- F. Individuals served by the **WWRC Brain Injury Services Department** typically receive multiple other services in addition to brain injury services from WWRC; therefore, financial data specific to those services is not available.
- G. No specific funding allocation is designated for **WWRC Spinal Cord Injury Services**. Overall, approximately 70 percent of WWRC funding comes from federal Title I vocational rehabilitation funds, 20 percent from state general funds, and 10 percent from fees for service, special funds, or grants.
- H. The number served by **DRS Community Rehabilitation Case Management (CRCM) Services** includes 379 on active caseloads as well as 329 receiving only technical assistance, making calculation of an average cost for services per person inappropriate.
- I. Federal Social Services Block Grant funding for services under the **Comprehensive Services Act (CSA)** are provided through the Virginia Department of Social Services (DSS) and, for financial reporting purposes, are considered to be state funds as reported in this table. Local governments are the source of other funds.
- J. Local governments have the option of maintaining waiting lists for non-mandated children; therefore, information is not available on the total number of children needing CSA services or who may be on waiting lists for them.
- K. An average cost for services per person by the **Centers for Independent Living (CILs)** is not provided because the number served is an estimate and allocated funds cover both direct services for individuals with disabilities as well as public awareness, technical assistance, and

training activities directed at service providers, organizations, families, and other broad categories of constituents.

- L. **Department for the Blind and Vision Impaired (DBVI)** staff members provide multiple services for persons with disabilities through several different programs with expenditures for both personnel costs and purchases of tangible goods and services spread across those programs. As a result, a calculation of average cost per person served for each program is not possible.
- M. The number served includes 2,302 individuals who received services from the **DBVI Rehabilitation Teaching/Independent Living (RT/IL) Program** and 562 who received **Orientation and Mobility** services.
- N. Expenditure information for non-waiver services for individuals with intellectual disabilities was provided by the **Department of Behavioral Health and Developmental Services' (DBHDS) Office of Community Contracting** from SFY 2010 performance reports submitted by **Community Services Boards (CSBs)**. Information by funding sources was not available.
- O. SFY 2010 data was not available from the **Virginia Department for the Aging (VDA)** for programs that it administers. For the previous year, SFY 2009, expenditures for local services provided by Area Agencies on Aging (AAAs) and other contracted agencies totaled \$52,709,018, with an average cost per person of \$893. This included \$11,796,728 in state general funds, \$26,828,979 in federal funds, and \$14,083,311 from other sources. That same year, the Public Guardianship Program expended \$1,869,645 in state general funds at an average cost per person of \$3,111. The Long-Term Care Ombudsman program expended \$1,648,521 in SFY 2009, with \$286,574 coming from state general funds, \$816,289 from federal funds, and \$545,658 from other sources. This reflected a significant increase from SFY 2007 expenditures of \$1,156,246 for the ombudsman program.
- P. Funding for services through the **DBVI Older Blind Grant Program** comes from other DBVI programs listed above under Independent Living and Related Services.

F. Monitoring and Evaluation of Community Supports

All Virginia state government executive branch agencies are required to establish goals, objectives, and outcomes for their programs in strategic plans and performance measures posted to the Virginia Performs website (www.vaperforms.virginia.gov). Oversight procedures for the programs discussed in this chapter are covered below, with specific monitoring and evaluation results cited as available.

Assistive Technology (AT) and Related Services: Activities of the **Department of Rehabilitative Services' (DRS) Virginia Assistive Technology System (VATS)** are guided and overseen by the **Virginia Council on Assistive Technology** based on a three-year plan that must be submitted to the **Rehabilitation Services Administration (RSA)**, VATS federal funding source, for approval. Information on activities and events sponsored by VATS is collected and compiled on a routine weekly, monthly, quarterly, and annual basis. This includes quarterly reports from its regional sites and the Virginia Reuse Network on how many individuals received

recycled AT devices, their values had they been purchased, and the resulting cost savings. Quarterly reports also include summative evaluations from large training programs and conferences. To ensure accountability, this information plus the results of client follow-up and satisfaction surveys are compiled at the state level, compared to VATS three-year plan as part of its annual program report to RSA, and used to make modifications to the plan as indicated.

AT services provided by the **Durable Medical Equipment (DME) Program at DRS' Woodrow Wilson Rehabilitation Center** are accredited by the **Accreditation Commission for Health Care**. In addition, information is routinely gathered on specific individual satisfaction measures, and based on the results of calls to individuals who have received wheelchairs or other DME through the WWRC AT program, therapists are assigned to contact those individuals for troubleshooting and other follow-up. All quality assurance information is tracked in a database, reviewed semi-annually to determine ways to improve service delivery, and further reviewed annually by the **WWRC AT Center of Excellence Focus Group**.

Customer comments received by the **Department for the Deaf and Hard of Hearing's (DDHH) Technology Assistance Program (TAP)** are routinely documented, and concerns are forwarded, as needed, to the appropriate Outreach Specialist, Program Coordinator, or the agency's Director, who is responsible for quality assurance. Procedural changes in the **TAP Loan-to-Own (L20)** program have significantly reduced the time required to receive equipment from up to six weeks to just several days. The DDHH 2010-2012 *Agency Strategic Plan* reports that nearly 100 percent of customers were "satisfied" or "very satisfied" with services received based on a survey implemented in 2009.

DDHH is responsible for managing and monitoring telecommunications contracts for all **Virginia Relay** services (*Code of Virginia*, 56-484.7) and for annual reports to the **Federal Communications Commission** on contractor performance and consumer feedback, including a log of all consumer complaints. Virginia Relay service contracts include specific steps for ensuring vendor compliance and for their response to individual complaints. User comments are compiled daily by Virginia Relay contractors and reported monthly to DDHH. DDHH oversight also includes routine test calls by agency staff and contracted external, independent testers; onsite quality assurance visits; and reviews of monthly performance and statistical reports as well as feedback from system users and members of the **Virginia Relay Advisory Council**. The DDHH *Agency Strategic Plan*, mentioned above, notes challenges to further improvement of service delivery. Video Relay Services (VRS) remain unavailable in rural areas where broadband or DSL infrastructure does not exist, and where VRS is available, its use is often blocked by businesses' internet security firewalls.

Oversight for the **NewWell Fund** is provided by a Board of Directors, the members of which include the state Secretary of Health and Human Resources or his or her designee, a WWRC employee, a representative from a consumer lender, a certified public accountant, two individuals with investment finance experience, and six individuals with disabilities (*Code of Virginia*, 51.5-56). A revised Governance Manual and updated bylaws, approved by the Board in 2007, establishes policies and procedures for consistent delivery of the authority's programs.

The NewWell Fund must also comply with requirements of the federal **Rehabilitation Services Administration (RSA)**, including an annual external audit analyzing day-to-day organization, administration, and finances and an annual report describing program activities. As a part of that report, the authority must tabulate the types and amounts of loans issued by the demographics of loan applicants. In its 2006 RSA report, the NewWell Fund identified critical issues, primarily related to increasing public awareness of its programs and enhancing its marketing and outreach to people with disabilities, as a future central priority. Since then, it has rebranded the loan program that funds equipment, supplies, or inventory for home-based businesses operated by individuals with disabilities as the “HomeWorks” Loan Program. A new brochure was finalized for broad marketing and distribution in 2010, and expansion of the program is underway. At the time of this assessment, a routine audit of the NewWell Fund was also in progress.

Brain Injury (BI) and Spinal Cord Injury (SCI) Services: The manager of the **Department of Rehabilitative Services’ (DRS) Brain Injury Services Coordination (BISC) Unit** is responsible for oversight of services provided by that and other related DRS programs, including the 12 contracted direct services programs across the state. Staff of the BISC Unit also provide support for the **Virginia Brain Injury Council**. Expenditures, activities, and outcomes are routinely monitored; issues of significance or concern are reported to the Community Based Services Division Director and DRS Commissioner on a weekly basis; and written reports are submitted annually to the DRS Commissioner via the Virginia Brain Injury Council, as well as to the **Virginia Disability Commission** and the General Assembly. These required annual reports cover the number of people served, types of services provided, and success in leveraging non-state resources.

The Virginia Brain Injury Council meets quarterly and, as a policy advisory group, makes recommendations to the Commissioner on how best to disseminate allocated state funding. Two additional groups, the **Virginia Alliance of Brain Injury Service Providers** and the **Brain Injury Association of Virginia (BIAV)**, also work closely with the Council and BISC staff to ensure accountability in the expenditure of funds for brain injury services. Suggestions and concerns raised by these organizations, internally by DRS staff, and by other community partners are considered by the council and brought to the attention of the Division Director and DRS Commissioner so that policy and procedure changes or other appropriate actions, if feasible, can be taken.

Organizations contracted by DRS to provide brain injury services are required to comply with state fiscal policies and controls and must submit financial and narrative progress reports on a monthly, quarterly, and annual basis. Annual reports must include evaluations, such as consumer satisfaction surveys, available to the contractors from internal or external sources. The BISC Unit’s last internal audit was completed in 2006 and, while no significant findings or exceptions were noted, it was recommended that contract language be revised to require that providers submit an annual external audit and control self-assessment document to DRS. Although these reports had been submitted by providers, they were not previously stipulated by their contracts. Along with implementation of this recommendation, the expectation that

providers would be accredited by the **Commission on Accreditation of Rehabilitation Facilities (CARF)**, was also made a requirement of their contracts.

Prior to 2007, the BISC Unit hired external consultants to evaluate performance by contracted service programs every two to three years. While this practice continues, contractors have been required, beginning that year, to submit expenditure and outcome data via a new online SCORECARD system that enables DRS to monitor contract compliance as well as program efficiency and effectiveness in a more structured and routine manner. During the first year of SCORECARD field testing, it was found that the formula for calculating the percentages of goals achieved and overall ratings of whether a contractor's performance met, exceeded, or was below expectations needed adjustment so that all of the resulting scores did not exceed expectations. Once the formula was adjusted, SCORECARD results were more aligned with what would be expected across the various programs. The SCORECARD system also requires programs to submit narrative reports to the manager of the BISC Unit that highlight achievements and notable success stories and that also detail reasons for any performance measures that are below expectations. Inconsistencies exist among contracted programs in how they report on their activities using the SCORECARD system, and discussions were held in December 2010 to address those inconsistencies.

In 2007, the manager of the BISC Unit also initiated an annual two-day general meeting of directors, program managers, and fiscal specialists from the state-funded brain injury contract service providers to provide technical assistance on administrative and oversight issues, promote sharing of best practices and collaborative efforts to improve service delivery, and provide an opportunity for program staff to present issues or concerns. A second two-day meeting was held in 2008; however, due to budget reductions, no meeting was held in 2009 and only a one-day meeting was held in 2010.

Although there is no formal internal evaluation of the **Brain Injury Direct Services (BIDS) Fund**, information on the number of individuals that it serves and the types and costs of services that it funds are included in the annual reports by the manager of the BISC Unit to the DRS Commissioner and Virginia Brain Injury Council mentioned above. Procedures to identify and address concerns about the use of the BIDS Fund are similar to those for other BISC Unit and Community Based Services activities. Requests for goods and services costing more than \$1,000 are reviewed by both the program manager of the BIDS Fund and the manager of the Community Rehabilitation Case Management (CRCM) Services program as a check and balance on the use of the BIDS Fund, and DRS has reports that no concerns have been expressed to-date on its management or effectiveness.

In response to a request from the DRS Commissioner, the Virginia Brain Injury Council commissioned a 2009 "white paper" by brain injury experts from across the state on neurobehavioral treatment options and needs in Virginia. The study report, *Neurobehavioral Treatment for Virginians with Brain Injury: A Virginia Brain Injury Council Position Paper*, identified a model system of care based on best practices and proposed a three-level system of

care demonstration project to address the needs of individuals with brain injuries. It recommended:

- Creation of an ongoing interagency agreement between DRS and the Departments of Juvenile Justice (DJJ), Medical Assistance Services (DMAS), and Behavioral Health and Developmental Services (DBHDS) to address the needs for brain injury services systematically statewide;
- Interagency review and update of current licensing regulations for non-Medicaid residential services to ensure implementation of best practices in assessment and treatment;
- Expansion of community-based neurobehavioral treatment services for individuals with brain injury as a central component of the state's *Olmstead* community integration goals and planning processes; and
- Modification of state Medicaid policies to cover in-state neurobehavioral programs, including those not designated as skilled nursing programs, and creation of a Medicaid Home and Community Based Services (HCBS) Brain Injury Waiver.

To integrate data collected by other state agencies with its own and improve the delivery of pre-hospital and hospital emergency medical services, the **Virginia Department of Health (VDH)** was given responsibility in 2008 for monitoring the incidence, severity, and causes of traumatic injuries (*Code of Virginia*, 32.1-116.1). In response, VDH combined two existing DRS-maintained databases, the Traumatic Brain Injury Registry and the Spinal Cord Injury Registry, with its own Virginia Statewide Trauma Registry (VSTR) to create the comprehensive **Emergency Medical Services Patient Care Information System (EMS-PCIS)**. Following their response to a traumatic injury, all licensed emergency medical services are required to notify this system of the nature of the emergency call and type of medical emergency, their response time, the treatment provided to individuals of all ages who received a diagnosis of brain or spinal cord injury, and other data that the Medical Emergency Services Advisory Board determines needs to be collected.

VDH shares information from the new EMS-PCIS registry with DRS so that it can better develop and implement services for individuals with brain or spinal cord injuries, and VDH reports that DRS has recently been provided with direct access to the data subset related to head and spinal cord injuries, enabling DRS to access data provided by hospitals in real time as frequently as desired. DRS reports, however, that the new registry, unlike the previous VSTR system, does not collect information on individuals who are treated and released by emergency medical departments. As a result, individuals with mild concussions or brain injuries may not receive outreach information about available services, and the DRS BISC Unit is exploring other ways to reach the individuals who were not admitted to the hospital.

Prior to the implementation of the new EMS-PCIS registry, the VSTR system documented hospital admissions for 7,635 individuals in state fiscal year (SFY) 2008 and 7,969 in SFY 2009. DRS conducts outreach through a contract with the Brain Injury Association of

Virginia (BIAV), and its most recent mailing to 3,500 individuals was completed in December 2010.

Internal processes at **DRS' Woodrow Wilson Rehabilitation Center** govern program capacity and resource allocation, and guidance on services by the **Brain Injury Services (BIS) Department** and Spinal Cord Injury Services programs is solicited from other management teams in the agency as well as from community partners and stakeholders. Reports summarizing the numbers served and service outcomes are shared monthly with WWRC's Director and the Director of the Medical Division. As a further part of the oversight process, the **Medical Division's Compliance Program** is involved in audits of individual case records that review admissions procedures, service provider documentation, medical coding, and billing practices; educates staff on compliance issues; and provides quarterly reports to the WWRC executive team. In addition, the manager of BIS Department serves as a state agency representative and non-voting, advisory member of the Virginia Brain Injury Council, reporting to it at least quarterly on WWRC programs and activities, and close links are also maintained with the Brain Injury Association of Virginia (BIAV) and the Virginia Alliance of Brain Injury Service Providers. Identification, discussion, and remedial activities based on these sources of feedback parallel those of other DRS programs.

Community Rehabilitation Case Management (CRCM) Services: Responsibility for oversight of **Department of Rehabilitative Services' (DRS) CRCM Services** rests with its program manager and the director of the **Community Based Services Division**. Monitoring processes have remained constant over time. Customer comments are routinely documented, and concerns are forwarded to the appropriate rehabilitation specialist, program manager, or assistant DRS commissioner as needed. Based on these comments, record reviews, and customer satisfaction surveys, areas needing improvement are identified, and policies are updated as indicated. At the time of this assessment, however, improvements to reporting mechanisms and to evaluations of individuals with disabilities, that were identified as needed in state fiscal year (SFY) 2009, have not been completed.

Comprehensive Services Act (CSA): The organizational structure and oversight provisions of the CSA are complex and cannot be covered in full detail in this assessment, but the basics are described below. State-level oversight consists of a two-tiered, multi-agency system. At the highest level, the **CSA State Executive Council (CSA-SEC)** is chaired by the Secretary of Health and Human Resources or his or her designee. Its other members include the Special Advisor to the Governor on Children's Services; representatives of the General Assembly, the Supreme Court of Virginia, a variety of state agencies, and local governments; public and private providers; two parents; and the Chair of the State and Local Advisory Team (SLAT) described below. The CSA-SEC is responsible for:

- Overseeing the interagency cooperation and collaboration necessary to implement CSA at both the state and local level,
- Appointing SLAT members,

- Establishing appropriate policies,
- Overseeing the use of CSA pool funds, and
- Advising the Governor and Cabinet Secretaries on proposed policy and operational changes.

The **Office of Comprehensive Services for At-Risk Youth and Families (OCS)** serves as the CSA-SEC's administrative body and works in partnership with other state agencies, localities, family organizations, and other stakeholders to improve CSA performance and ensure compliance with CSA-SEC policies. It provides policy development, fiscal management, data collection and management, information, and oversight for localities and maintains an authorized provider database. OCS also coordinates technical assistance, resources, training, best practices dissemination, and management reports to support community CSA systems and, when requested by localities, provides utilization management services for some residential programs.

OCS conducts both routine and special on- and offsite compliance reviews of local operations to identify training and technical assistance needs and to assess the overall level of statewide compliance with requirements. If program-specific concerns are identified, staff from appropriate agencies may be called in to assist in the review process. Following a review, a summary is provided to the Chair of the local Community Policy and Management Team (CPMT) and shared with others as appropriate. The summary contains information collected during the review, requests for corrective plans for any areas needing remediation, and recommendations for training or technical assistance when appropriate.

The **State and Local Advisory Team (SLAT)** mentioned above makes up the second tier of the state CSA system. Its membership includes staff members from relevant state agencies, parent and provider representatives, a judge, a local CSA coordinator, and five regional representatives who serve on local Community Policy and Management Teams (CPMT). SLAT advises the CSA-SEC on policy and operationalizes CSA-SEC decisions.

While municipalities are required by Virginia law to establish their own two-tiered systems involving a **Community Policy and Management Team (CPMT)** and a **Family Assessment and Planning Team (FAPT)**, they are otherwise given considerable flexibility in designing and delivering CSA services that best fit their situations. To ensure that services are appropriate, cost effective, provide the best possible outcomes for at-risk youths and families, and are in compliance with CSA policies and procedures, localities must have a system in place for review of diagnoses, reasons for services, referrals, and other case data as well as program data on service delivery, quality, and costs. Local reviews may also identify technical assistance and training needs and call attention to policy issues requiring attention at the local or state levels.

The *Evaluation of Children's Residential Services Delivered Through the Comprehensive Services Act*, a 2007 **Joint Legislative Audit and Review Commission (JLARC)** research report (<http://jlarc.state.va.us/Reports/Rpt346.pdf>), found that, despite CSA's focus on keeping

children with their families, at least 54 percent of all CSA expenditures in 2006 were for residential services, which on average were four times as expensive as community-based services. The report identified gaps in community services as a significant contributing factor and noted that receipt of services in an inappropriate (residential) program was found to result in adverse outcomes, such as poorer transition to homes and schools and exacerbated emotional or behavioral problems.

OCS has implemented numerous efforts to address the issues and recommendations from the JLARC report. To strengthen CMPTs and FAPTs, the OCS developed and distributed service models for needs assessments, policy guidelines, assessment tools and skills training, planning, and systems coordination, and four regional OCS technical assistance coordinators are also available to provide CMPTs and FAPTs with ongoing training and consultation. OCS has also modified the CSA data set to capture provider-specific information, mandated use of the Child and Adolescent Needs and Strengths (CANS) standardized assessment instrument described earlier, and in state fiscal year (SFY) 2007 began implementation of an Innovative Community Services Grant program to reduce over-reliance on residential programs.

Six of these grant projects involving 16 local governments were funded in SFY 2007 and 2008. Four of the projects, scheduled to last for 15 months, funded transitional care coordinators to work intensively either with designated children in residential placements to transition them back home or with children at great risk of residential placement to keep them in the home. One of these projects also involved contracting to provide “Wraparound 101” training to all case managers, individual case coaching, and consultation with project staff and the CPMT on a regular, ongoing basis. Another locality established a Multi-Dimensional Treatment Foster Care Program, an evidence-based model of intervention and services for older children. The final locality created a “host home” program called “Parents and Children Together,” that allowed families with children at risk to live in foster homes where the foster parents mentor the child’s parents and assist them in moving towards independence and self-sufficiency. By March 2010, this latter grant, located in Hampton, had trained 37 families, three remained in the program, and no children had returned to foster care.

Funding for these innovative grants was not re-appropriated by the General Assembly after the initial grant period due to budget reductions; however, the six projects described above effectively served as pilots for legislative authorization in the *2009 Appropriations Act of Intensive Care Coordination*, as a new CSA service to be provided by local Community Services Boards (CSBs). Like the transitional care coordinators funded by the innovative grants, Intensive Care Coordinators work to “wrap” services around a family that will either permit a child to return home from a residential placement or avoid placement of a child in a residential program.

CSA data indicates significant changes in outcomes as a result of these and other initiatives. For example, localities’ effective match rate rose steadily prior to state fiscal year (SFY) 2009, when the community-based services match rate incentive described earlier in the access and delivery section of this chapter was implemented. In the two years since then, it has

declined to 33.33 percent. At the same time, total CSA expenditures have also decreased, by four percent in SFY 2009 and five percent in SFY 2010. The SFY 2009 decrease in expenditures was the first since the implementation of CSA and resulted in annual savings of approximately \$36 million. Localities realized approximately \$14 million in savings that year compared to SFY 2008.

The CSA's *State Executive Council Biennial Report* for 2009 lists additional meaningful CSA changes since 2007:

- The number of foster care youth in group home settings decreased by 40 percent,
- The percentage of youth being discharged into permanent families increased by six percent, and
- The percentage of youth served in group settings decreased from 26 to less than 17 percent.

OCS conducts an annual Critical Services Survey of localities regarding available community services, barriers to services, and service gaps. Its survey for SFY 2009, the fourth conducted, found that crisis intervention services remained the most important critical service need statewide, reflecting no change from the previous three years. The survey also reported a continuing need for intensive substance abuse services for youth in the western, central, and northern regions of state. Not surprising in light of the activities and incentives described above, 77 percent of respondents indicated that their localities had developed new community-based services and that the use of congregate care had been correspondingly reduced. By region, the primary service gaps were:

- Northern Region: Intensive Crisis and Stabilization Services,
- Central Region: Transportation,
- Eastern Region: Regular Family Foster Care,
- Piedmont Region: Psychiatric Assessment, and
- Western Region: Intensive Substance Abuse Services.

Independent Living and Related Services: Under both state and federal statutes, responsibility for oversight of services provided by **Centers for Independent Living (CILs)** rests with their executive directors, individual governing boards, and the **Department of Rehabilitation Services (DRS)** through the Independent Living Services office of its **Community Based Services Division**. DRS oversight is accomplished through site visits and monitoring of CIL activities as well as review of quarterly and annual reports, financial audits, and evaluation of the outcomes of CIL services. Outcome measures track achievement of program activities planned by the CILs, local and statewide training for CIL staff and individuals with disabilities, and local efforts related to statewide systems change initiatives. Examples of the latter include increased access to Medicaid Home and Community Based Services (HCBS) Waivers, increased transportation services, expanded housing options, and the number of individuals who have

transitioned from nursing facilities to community residences or who have been able to avoid entering nursing homes due to CIL support.

Since CIL core services are consumer-directed, feedback from individuals with disabilities receiving services is a crucial part of service implementation and evaluation, and all CILS collect this feedback through a variety of mechanisms. Many have a consumer advisory committee that designs, distributes, and collects responses to a consumer satisfaction survey in a process independent of the CIL staff. Results of these surveys are submitted to their respective executive directors and boards with recommendations for service improvements, changes, or additions.

The **Department for the Blind and Vision Impaired's (DBVI) Rehabilitation Teaching/Independent Living Program** is overseen by a director, assisted by six regional managers who supervise and evaluate the performance of the rehabilitation teachers who deliver RT/IL services. The RT/IL Program's director and regional managers also review case records and accompany the rehabilitation teachers in the field to monitor their effectiveness. Quality assurance procedures for **DBVI Older Blind Grant Program, DeafBlind Services, and Low Vision Services** are similar; however, the program director for Low Vision Services has the additional responsibility for hiring, training, and monitoring the contracted examiners who provided direct services for the program's clients. Periodic performance evaluations of these examiners are reviewed by the Low Vision Services program's director and regional office staff, and if examiners are found to be noncompliant with DBVI policies and practices, their contracts may be cancelled.

The DBVI central office also conducts annual case reviews for each of the regional offices and solicits feedback on services from DVBI's clients and other stakeholders through periodic customer satisfaction surveys and other appropriate means. When problems are detected, corrective actions may result in additional staff training, casework corrections, or other personnel actions. The program directors may modify their policy manuals or arrange for general training to increase the effectiveness of a program. As a recipient of funding from the federal **Rehabilitation Services Administration (RSA)**, DBVI is further required to submit an annual report to that agency, and if RSA finds it to be noncompliant, DBVI must submit a corrective plan indicating the actions to be taken and their projected completion dates.

The DVBI 2008-2010 *Agency Strategic Plan* identified the large size of RT/IL staff caseloads and territories as having a negative impact on the frequency of training lessons, which in turn negatively impacts client skill acquisition. DBVI continues to investigate strategies to improve service delivery and reduce the administrative burden on staff to free time for direct services for individuals. Many DBVI staff now telework from home or other locations helping them serve clients more efficiently by reducing commuting time to and from the office.

In October 2008, to further improve its efficiency and effectiveness, DBVI implemented the **AWARE Case Management System** in partnership with the Department of Rehabilitative Services (DRS). The AWARE system's online tools have enabled DBVI to integrate case

management documentation across all program areas, resulting in better communications, an expedited service authorization process, and improved service delivery. The system has also improved DBVI's ability to budget funds used for customer services and track how those funds are spent over time.

(Non-Waiver) Intellectual Disability Services: As the state's lead agency for intellectual disability services, the Department of Behavioral Health and Developmental Services (DBHDS) licenses public and private providers of intellectual disability services, supplies them with technical guidance, and oversees protection of human rights. For the five state-operated training centers and the 40 local Community Services Boards (CSBs), DBHDS is responsible for operational and fiscal oversight, budgeting and allocation of state funds, and quality assurance.

The key DBHDS accountability tool is the annual *Community Services Performance Contract*, signed by the DBHDS Commissioner and CSB executive directors, that contains numerous data collection and accountability mechanisms to ensure state and federal regulatory compliance and a quality improvement approach to performance. The *Central Office, State Facility, and CSB Partnership Agreement* incorporated into the contract defines system values, delineates roles for each participant that establish a collaborative operational partnership, and identifies processes for improving the quality of care throughout the DBHDS public service system. Locally, administration of each of the CSBs is further guided by a board of directors consisting of six to 18 members appointed by the local governing bodies within their areas of jurisdiction.

The **DBHDS Office of Community Contracting (OCC)** is primarily responsible for negotiating and monitoring the performance contract and works with other DBHDS offices that conduct and document CSB compliance activities pertaining to specific contract requirements. Onsite reviews of CSB client records and fiscal documents are an important part of these monitoring activities; however, DBHDS reports that limited staffing makes conducting them a challenge. When such reviews do occur and compliance issues or deficiencies are found, DBHDS attempts to resolve them initially through informal, then formal, mechanisms that include discussion, negotiation, correspondence, or corrective action plans. If these efforts are not successful, the performance contract allows for other means of resolution that, as a rare and last resort, can include withdrawal of state funding from the applicable service or program.

The **DBHDS Office of Licensing (OL)** is responsible for overseeing application of DBHDS licensure standards, policies, and procedures for the hundreds of providers of treatment, training, and habilitation services for individuals with mental illness, intellectual disability, or substance abuse disorders statewide that must adhere to state regulations. These include providers of day support, in-home residential, or crisis stabilization services under the Medicaid Home and Community Based Services (HCBS) Individual and Family Developmental Disability (DD) Waiver. Licensing staff investigate complaints against providers, which may operate multiple programs or services, and are required to make at least one unannounced inspection of each provider, each year. Staff of the licensing office also train new providers,

supply ongoing technical assistance, and have responsibility for prior authorization of services and supports.

The table below, covering selected state fiscal years (SFY) between 2005 and 2010 and the total change for that period, shows the rate of growth for the work of the licensing office. While the number of providers, services, and service locations has grown significantly, the number of licensing staff positions has remained constant at 15, resulting in substantially higher workloads. To partially address this issue, extensive guidance materials from the licensing office are now available online. The office has also produced training materials in electronic formats for purchase by new providers.

NUMBER OF DBHDS LICENSED PROVIDERS, SERVICES, AND LOCATIONS

State Fiscal Year	2005	2006	2007	2010	Change	Percent
Providers	457	481	529	697	+240	+52.5%
Services	1,084	1,175	1,257	1,662	+578	+53.3%
Locations	2,684	2,764	2,970	5,037	+2,353	+87.7%

Sources: Department of Behavioral Health and Developmental Services (DBHDS), Office of Licensing *Annual Reports* for SFYs 2006, 2007, 2008, and 2010.

The **DBHDS Office of Human Rights (OHR)** is responsible for protecting the legal and human rights of individuals receiving services in state facilities and the community-based programs operated, licensed, or funded by DBHDS (*Code of Virginia, 37.2-400*), with the exception of those operated by the Department of Corrections. In doing so, the human rights office monitors compliance with relevant regulations, promotes the basic precepts of human dignity, advocates for the rights of persons with disabilities, manages the DBHDS human rights dispute resolution process, and supports the work of 80 **Local Human Rights Committees** across the state.

In SFY 2007, the DBHDS Office of Human Rights had 23.5 staff positions for human rights advocates, but as a result of budget cuts and lost positions, that number declined to 19 in SFY 2009 and 18 in SFY 2011, despite the substantial increase in the number of providers, services, and locations to be monitored shown in the table above. In its 2009 annual report (www.dbhds.virginia.gov/documents/reports/OHR-SHRC2009AnnualReport.pdf), the **State Human Rights Committee** expressed deep concern about the negative impact of these cuts in staffing, stating that:

“The loss of these positions impacts every region of the state. At risk is the availability of OHR staff to promote provider compliance with the regulations through consultation and guidance and site visits; respond to human rights complaints; investigate allegations of abuse and neglect; and provide training to consumers, providers and professionals.”

The General Assembly created the **Office of the Inspector General for Behavioral Health and Developmental Services (OIG)** in 2000 to “inspect, monitor, and review the quality

of services provided” by state facilities and public or private entities or organizations that provide community services for persons with intellectual disabilities, mental illness, or substance abuse disorders (*Code of Virginia*, 37.2-423). The Inspector General who heads this office is appointed by the Governor, subject to confirmation by the legislature, for a four-year term that is not coincident with the Governor’s term, and is required to keep the Governor, General Assembly, and Joint Commission on Health Care fully informed of significant problems or deficiencies within the service system and to make recommendations for corrective actions.

Initially, OIG inspections focused on services at state mental health facilities and the state-operated training centers that provide services for individuals with intellectual disabilities, but in 2005, they were expanded to include investigations of community services. This extension of the OIG’s oversight responsibilities specifically included services funded through the Medicaid Home and Community Based Services (HCBS) Individual and Family Developmental Disability (DD) Waiver and Brain Injury Waiver, residential services for persons with brain injury, and individual providers, with the exception of certain practitioners such as those licensed through the board of the Department of Health Professions (DHP). As a part of this legislative change, the OIG now routinely monitors serious incident reports as well as citizen reports of abuse, neglect, or inadequate care by these providers and is authorized to make announced and unannounced inspections of providers to prevent problems or deficiencies and improve service effectiveness.

In addition to investigations and monitoring activities described above, the OIG responds to complaints and requests for information or referral from service recipients, employees of service providers and other citizens on a variety of issues. Its semi-annual reports note 41 such responses between April 1 and September 30, 2009; 23 between October 1, 2009 and March 31, 2010, and 20 between April 1 and September 30, 2010. Information about the OIG’s onsite inspections of the state-operated training centers is summarized in the Institutional Services chapter of this assessment.

With the exception of some OIG investigations that remain unpublished as Governor’s Confidential Working Papers because of executive privilege or the privacy rights of individuals served or their caregivers, the OIG’s website (www.oig.virginia.gov/Reports.htm) provides public access to reports summarizing its investigative findings and recommendations. From state fiscal years (SFYs) 2008 through 2010, OIG staff completed several studies of community services licensed by Department of Behavioral Health and Developmental Services (DBHD) that are briefly described below:

- **OIG Report #149-08, *Review of CSB Children and Adolescent Services*** (issued September 19, 2008): The OIG conducted an extensive survey in 2007 of all Community Services Boards (CSBs) to identify the services being provided, the structure of those services, staffing levels and types, budgets, and factors helping or hindering development of services for youth. Phase 2 of this study, in March and April of 2008, was based on site visits to 34 CSBs. Extensive case record reviews were conducted, and interviews were held with over 1,000 CSB direct service staff and supervisors as well as 175 family

members or guardians. The OIG found wide variability among communities in service availability and that CSBs with the most extensive services for youth provided them by accessing Medicaid resources. The study further found that access to CSB services for youth and families who were uninsured was “extremely limited” statewide.

- **OIG Report # 183-09, *Review of Residential Crisis Stabilization Units Operated or Contracted by Community Services Boards*** (issued February 9, 2010): The OIG conducted onsite reviews of 14 residential crisis stabilization units (CSUs) for adults that were either operated by or contracted by the CSBs to assess their effectiveness in helping individuals avoid hospitalization. OIG staff, along with trained peer inspectors, reviewed clinical records and interviewed direct care staff, supervisors, current and former clients, and other stakeholders. The review found that DBHDS did not clearly establish expectations for program criteria, mission, target populations, or data requirements and that few CSUs accepted individuals who met temporary detention order (TDO) or involuntary commitment criteria.
- **OIG Report #195-10, *Unannounced Inspection at The Pines (Crawford Campus), Portsmouth, Virginia*** (issued October 13, 2010): The Pines, a secured residential treatment facility, serves youth under age 22 who have a diagnosis of mental illness or intellectual disability and a history of assaultive or self-injurious behaviors. About 22 percent of its residents are from Virginia, and most either transferred from correctional facilities or were placed at The Pines by public agencies. The Pines has a history of noncompliance with state licensure requirements and had an extensive Corrective Action Plan in effect. Upon request by the legislative Commission on Youth, the OIG reviewed documentation from the DBHDS Office of Licensing (OL), conducted interviews with OL staff and Pines staff, reviewed Pines documentation, and conducted a site visit. The OIG did not find any current evidence of abuse, neglect, or inadequate care that warranted a formal investigation; however, the OIG emphasized that effective risk management and ongoing quality improvement initiatives were essential to sustain improvements.

Additional investigative and monitoring activities by the OIG are summarized in its semi-annual reports, which are also posted to its website. The activities described briefly below are covered in more detail in those reports.

Following the OIG’s 2007 *Review of Community Services Board Intellectual Disability Case Management Services for Adults*, the Department of Behavioral Health and Developmental Services (DBHDS) informed the OIG that it planned to establish a workgroup to address specific OIG findings and recommendations. The OIG’s October 2010 semi-annual report noted, however, that DBHDS informed the OIG in 2009 that the workgroup had not “...been effectively established so consequently a number of recommendations made by the OIG were never addressed.” Subsequently, in late 2010, DBHDS implemented a taskforce to examine the issues and improve case management services, and the OIG is monitoring this taskforce’s efforts.

The OIG is also monitoring progress by DBHDS to implement the goals and objectives recommended as priorities by the workgroups that produced the *Creating Opportunities* plan described in the introduction to this chapter. A recent, 2010 OIG semi-annual report noted that “development of a ‘model’ service planning system and format that is person-centered... and meets all regulatory requirements” was a recommendation that had still not been addressed. DBHDS has, nevertheless, taken steps in this direction. As a part of the statewide Systems Transformation Grant initiative, also described in the introduction to this chapter, DBHDS has begun a person-centered thinking (PCT) training initiative to improve intellectual disability services provided both at its state-operated training centers and by CSBs. Since 2008, training in the person-centered Individual Support Planning process for the Medicaid Home and Community Based Services (HCBS) Intellectual Disability (ID) Waiver has been conducted for 3,582 staff from CSBs and other public and private nonprofit or for-profit provider agencies, and by the end of state fiscal year (SFY), Virginia will have qualified 18 PCT trainers and three PCT mentors who, in turn, can instruct and qualify additional PCT trainers.

To address another ongoing concern identified by the OIG, DBHDS has collaborated with the Virginia Association of Community Services Boards (VACSB) and the Intellectual Disability Council to identify service gaps for persons who have intellectual disabilities and either a concurrent diagnosis of mental illness or exhibit challenging behaviors and develop a plan to address those gaps. In October 2010, the VACSB released a report responding to this request based on historical data and services available in each of the five CSB regions. The report recommended the establishment of crisis response teams (CRT) and crisis stabilization units (CSU) in each of the five CSB regions. This initiative, estimated to cost \$3,649,860 in state general funds augmented by Medicaid and other insurance, called for:

- Adoption of a statewide service model centered on implementation of CSUs and mobile CRTs in each CSB region,
- Allowing funding of mental health crisis intervention and stabilization services under the Medicaid State Plan for individuals with intellectual disabilities in crisis who do not have a Medicaid Home and Community Based Services (HCBS) Waiver, and
- Creation of an evaluation process to assess effectiveness upon funding and implementation of the model.

Interpreter Services and Related Programs for the Deaf and Hard-of-Hearing: The Virginia Department for the Deaf and Hard of Hearing’s (DDHH) Interpreter Services Program and related Virginia Quality Assurance Screening (VQAS) Program as well as its Outreach Program are overseen by program managers and the agency’s director. As a part of this oversight, program statistics and customer feedback are reviewed routinely on an ongoing, informal basis.

The VQAS diagnostic and proficiency instrument is used to assess the knowledge, skills, and abilities of interpreters and other professionals who facilitate communications for individuals with hearing or speech impairments. Regularly prepared Rater Report Cards ensure consistency

and effectiveness, annual training is provided, and if an individual's performance falls outside of expected standards, retraining is provided. If a complaint is received about a nationally certified interpreter assigned by DDHH, the agency recommends that the complainant file a formal complaint with the certifying body, usually the Registry of Interpreters for the Deaf, Inc. If the complaint involves an interpreter qualified by the VQAS Program, the interpreter must participate in a counseling session to review Interpreter Services Program's code of ethics and other contract requirements. Depending on the outcome of the formal complaint, provisions of that contract allow for its termination by DDHH.

Omnibus Budget Reconciliation Act (OBRA) Services: The **Virginia Department of Rehabilitative Services' (DRS)** is responsible for overseeing that providers of OBRA services for individuals with "related conditions," such as a developmental disability other than an intellectual disability, comply with federal regulations. DRS also monitors performance measures related to OBRA administration under a contractual agreement with the **Department of Behavioral Health and Developmental Services (DBHDS)** and consults with its DBHDS liaison on an ongoing basis. Customer comments are routinely documented and concerns are forwarded to the appropriate rehabilitation specialist, program coordinator, and division director as needed. State agencies participating in the OBRA program report improved overall consumer satisfaction due to programmatic changes and revisions, including more access to rehabilitation engineering and specialized services.

(Non-Waiver) Personal Assistance (PAS) Services: The **State-Funded PAS and PAS for Individuals with Brain Injury (PAS/BI)** are overseen by a program manager and the director of the **Department of Rehabilitative Services' (DRS) Community Based Services Division**. A PAS Advisory Committee comprised of individuals with disabilities, representatives from Centers for Independent Living (CILs), and agency representatives meets quarterly to review the programs and make recommendations for improvements. Feedback is also obtained through consumer satisfaction surveys and other contacts with individuals with disabilities, their families and personal assistants, and the CILs. Internal record reviews and program audits by DRS identify additional areas for improvement, such as recent updates to PAS program policies, the *Consumer Personal Assistance Services Handbook*, and various program forms.

Services for the Elderly Population: As noted earlier, the **Virginia Department for the Aging (VDA)** has been legally designated as the state's "unit on aging" by the federal Administration on Aging and is responsible for oversight of all Virginia programs funded through the federal *Older Americans Act*. It is also responsible for oversight of programs funded through state appropriations and for periodically evaluating the social, physical, and economic needs of older Virginians to determine the extent to which public and private programs are meeting those needs. In addition to planning, coordinating, funding, and evaluating all publicly funded programs for older Virginians, VDA provides staff support for three state advisory boards whose members are appointed by the Governor and General Assembly: the Commonwealth Council on Aging, the Alzheimer's Disease and Related Disorders Commission, and the Virginia Public Guardian and Conservator Advisory Board.

VDA serves as an advisor to the **Area Agencies on Aging (AAAs)** and other contractors that implement services for the elderly population and ensures that those problems meet quality standards. Those service standards are posted to the VDA website and cover recordkeeping, appeals processes, federal and state laws, medication management, use of the Uniform Assessment Instrument (UAI), and other program-specific matters. VDA conducts fiscal and program reviews of programs the AAAs and its contractors and provides onsite technical assistance when needed. When deficiencies are noted, contractors may be required to prepare and implement corrective action plans.

The Public Guardian and Conservator Advisory Board consists of 15 members appointed by the Governor to represent specific organizations or constituencies (*Code of Virginia, 2.2-2411*), advises the VDA Commissioner, and assists VDA staff in the coordination, management, and oversight of **Virginia Public Guardianship Program**. During state fiscal years (SFYs) 2010 and 2011, VDA has been conducting an extensive monitoring review of all local public guardianship programs, reviewing at least 80 percent of client records at each local program. The data collected will be used to establish a performance baseline for future monitoring to ensure compliance with state law and Circuit Court orders. In subsequent years, VDA will annually review a randomly selected sample of at least 25 percent of client records at each program. According to VDA, the quality of local guardianship programs is good, but their scope is currently limited by funding that is inadequate to serve all those needing guardians or conservators. With the number of Virginians ages 65 and older anticipated to rise dramatically in the future, VDA is concerned that the need for public guardianship and other services for this population will only increase.

VDA also has statutory responsibility (*Code of Virginia, 2.2-704*) for receiving, investigating, and resolving complaints made by or on behalf of older Virginians regarding long-term care services provided by state agencies, AAAs, or any other public or private nonprofit or for-profit entities. To do so, it contracts with the Virginia Association of Area Agencies on Aging (VAAAA) to operate the **Long-Term Care Ombudsman Program** and 21 AAAs that provide local ombudsman services. This program works in collaboration with regulatory agencies and programs such as the adult protective services units of local social services departments to foster a non-adversarial process “empowering persons to resolve complaints themselves when appropriate.” To ensure coordinated statewide access, VDA operates a toll-free hotline for information and referrals and requires program staff members to complete a certification curriculum. During state fiscal year (SFY) 2009 the program served 1,879 adults with disabilities and elderly individuals with and without disabilities, an increase of 16.4 percent (265 persons) over SFY 2007. As above, VDA is concerned about this program’s ability to meet growing service needs with limited funding.

Basic oversight practices for the **Department for the Blind and Vision Impaired’s (DBVI) Older Blind Grant Program** are similar to and intertwined with oversight for DBVI’s other programs as explained above under independent living and related services. In addition to these practices, DBVI contracts with Mississippi State University to conduct an annual program

performance evaluation that includes a customer satisfaction survey of a random sample of all individuals who have received services and an onsite visit to observe rehabilitation teachers who work with Older Blind Grant customers.

State regulations (12 VAC 30-120-62) assign primary responsibility for oversight of the **Program of All-Inclusive Care for the Elderly (PACE)** to the **Virginia Department of Medical Assistance Services (DMAS)**. This includes determination of whether to extend PACE coverage to another area of the state, the schedule for doing so, and implementation of the **Request for Application (RFA)** process (12 VAC 30-120-1060). When an entity is selected in response to an RFA, DMAS conducts a feasibility study to determine whether that entity has the ability and resources necessary to effectively operate a PACE program, and DMAS can only contract with those providers who receive a positive determination. Each PACE provider must meet all conditions of participation required by federal Centers for Medicare and Medicaid (CMS) regulations (42 CFR, Part 460) and relevant state statutes (*Code of Virginia*, 32.1-330.2 and 330.3), as well as DMAS regulations, policies, and procedures. Prior to implementation, DMAS conducts an onsite **State Readiness Review** and, as noted earlier, provides training to all preadmission screeners in localities covered by the new PACE program.

Following implementation, DMAS conducts quarterly **Quality Management Reviews** of each PACE program, and in collaboration with DMAS, CMS also conducts an onsite review and evaluation of each PACE program. All reviews include a thorough examination of all PACE processes and procedures, care plans, and participants' medical records to ensure that the health, safety, and welfare of all PACE participants are protected and that each program is in compliance with both federal and state regulations. DMAS also conducts participant and family satisfaction surveys for each PACE program to gather information about enrollment procedures, information sharing, participant care, and other program features. If a noncompliance by a provider is significant enough to warrant such action, DMAS can retract Medicaid payments, terminate the provider agreement, or do both.

G. Community Supports Sources Referenced in This Chapter

Links to websites and online documents reflect their Internet addresses in March 2011. Some documents retrieved and utilized do not have a date of publication.

Websites:

Brain Injury Association of Virginia (BIAV):

www.biav.net

NewWell Fund:

www.newwellfund.org

Office of the Attorney General of Virginia:

www.oag.state.va.us

Office of the Inspector General (OIG) for Behavioral Health and Developmental Services:

www.oig.virginia.gov

OIG Reports:

www.oig.virginia.gov/Reports.htm

Office of the Secretary of Health and Human Services (HHR) of Virginia:

www.hhr.virginia.gov

Systems Transformation Initiatives:

www.hhr.virginia.gov/Initiatives/SystemsTransformation

SeniorNavigator:

www.seniornavigator.org/ccss_overview.php

Statewide Independent Living Council (SILC):

www.vasilc.org/statewideindependentlivingcouncil.htm

U.S. Administration on Aging (AOA):

www.aoa.gov

Community Living Program:

www.aoa.gov/AoARoot/AoA_Programs/HCLTC/NHD/index.aspx

Virginia Association of Area Agencies on Aging (VAAAA):

<http://vaaaa.org>

Virginia Association of Community Services Boards:

www.vacsb.org

Virginia Auditor of Public Accounts (APA):

www.apa.virginia.gov

Audit Reports:

www.apa.virginia.gov/reports.cfm

Virginia Department for the Aging (VDA):

www.vda.virginia.gov

Area Agencies on Aging:

www.vda.virginia.gov/aaalist.asp

Community Living Program:

www.vda.virginia.gov/communityliving.asp

No Wrong Door Initiative:

www.vda.virginia.gov/nowrongdoor.asp

Public Guardianship and Conservatorship Program:

www.vda.virginia.gov/vapublicguardpgm.asp

Virginia Department for the Blind and Vision Impaired (DBVI):

www.vdbvi.org

Rehabilitation Teaching/Independent Living:

www.vdbvi.org/RTILS.htm

Older Blind Grant Program Annual Reports:

<http://www.vdbvi.org/OBGPAR.htm>

Virginia Department for the Deaf and Hard-of-Hearing (DDHH):

www.vddhh.org

Interpreter Services:

www.vddhh.virginia.gov/IpAbout.htm

Technology Services:

www.vddhh.virginia.gov/TechIntro.htm

Virginia Relay:

www.varelay.org

Virginia Department of Behavioral Health and Developmental Services (DBHDS):

www.dbhds.virginia.gov

Office of Community Contracting:

www.dbhds.virginia.gov/OCC-default.htm

Office of Developmental Services:

www.dbhds.virginia.gov/ODS-default.htm

Person Centered Practices:

www.dbhds.virginia.gov/ODS-PersonCenteredPractices.htm

Office of Human Rights:

www.dbhds.virginia.gov/OHR-default.htm

Office of Licensing:

www.dbhds.virginia.gov/OL-default.htm

Office of Planning & Development:

www.dbhds.virginia.gov/OPD-default.htm

Omnibus Budget and Reconciliation Act (OBRA):

www.dbhds.virginia.gov/omh-obra.htm

Virginia Department of Health (VDH):

www.vdh.virginia.gov

Division of Long Term Care:

www.vdh.virginia.gov/OLC/LongTermCare

Office of Licensure and Certification:

www.vdh.virginia.gov/OLC/index.htm

Virginia Department of Medical Assistance (DMAS):

www.dmas.virginia.gov

Children's Mental Health Demonstration Waiver:

http://dmasva.dmas.virginia.gov/Content_atchs/mch/mch-cmh1.pdf

Division of Long Term Care:

http://dmasva.dmas.virginia.gov/Content_pgs/ltc-home.aspx

Program of All-Inclusive Care for the Elderly (PACE):

http://dmasva.dmas.virginia.gov/Content_pgs/ltc-pace.aspx

Virginia Department of Planning and Budget (DPB):

www.dpb.virginia.gov

Virginia Department of Rehabilitative Services (DRS):

www.vadrs.org

Brain Injury Services Coordination (BISC):

www.drs.virginia.gov/cbs/biscis.htm

Virginia Brain Injury Council:

www.drs.virginia.gov/vbic.asp

Community Based Services:

www.drs.virginia.gov/community.htm

Community Rehabilitation Case Management (CRCM):

www.drs.virginia.gov/cbs/ltrcm.htm

Personal Assistance Services:

www.drs.virginia.gov/cbs/pas.htm

Virginia Assistive Technology System (VATS):

www.vats.org

Virginia Reuse Network:

www.vats.org/atrecycling.htm

Woodrow Wilson Rehabilitation Center:

www.wwrc.virginia.gov

Brain Injury Services:

www.wwrc.virginia.gov/braininjuryservices.htm

Spinal Cord Injury Program:

www.wwrc.virginia.gov/spinalcordinjury.htm

Virginia Office of Comprehensive Services (OCS) for At-Risk Youth & Families:

www.csa.state.va.us/index.cfm

Child and Adolescent Needs and Strengths (CANS) Assessment:

www.csa.state.va.us/html/CANS/cans.cfm

CSA Statewide Statistics and Reports:

www.csa.virginia.gov/publicstats/index.cfm

Systems of Care:

www.csa.state.va.us/html/systems_of_care/systems_of_care.cfm

Virginia Easy Access:

www.easyaccess.virginia.gov

Virginia General Assembly:

<http://legis.state.va.us>

2011 State Budget:

<http://leg2.state.va.us/MoneyWeb.NSF/sb2011>

Code of Virginia:

<http://leg1.state.va.us>

House Appropriations Committee:

<http://hac.state.va.us/welcome.htm>

Joint Legislative Audit and Review Commission (JLARC):

<http://jlarc.state.va.us>

Study Reports and Briefings:

http://jlarc.state.va.us/pubs_rec.htm

Senate Finance Committee:

<http://sfc.virginia.gov/index.shtml>

Virginia Administrative Code:

<http://leg1.state.va.us/cgi-bin/legp504.exe?000+men+SRR>

Virginia Office for Protection and Advocacy (VOPA):

www.vopa.state.va.us

Virginia Performs:

www.vaperforms.virginia.gov

Health and Human Resources Secretariat:

www.vaperforms.virginia.gov/agencylevel/src/secretariat.cfm?sec=Health

State agency Strategic Plans:

www.vaperforms.virginia.gov/agencylevel/index.cfm

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VII. Institutional Services

A. Introduction

This chapter focuses on three types of institutions in Virginia that serve individuals with intellectual or other developmental disabilities (ID and DD, respectively): Training centers operated by the state and certified as Intermediate Care Facilities for Persons with Mental Retardation (ICFs-MR) plus community-based ICFs-MR and nursing facilities (nursing homes) licensed by the state but operated by local public agencies and private nonprofit or for-profit organizations. All of the state's training centers as well as most community ICFs-MR and nursing facilities are certified for Medicaid or Medicare reimbursement for services and monitored by state agencies on a regular basis. While each category of institution has unique characteristics based on its function, all provide daily room and board as well as varying levels of health care and other services. Throughout this chapter, in keeping with national reports, references to "large" institutions apply to those having a building or unit with a capacity for 16 or more residents.

Federal regulations (CFR 440.150), based on the *Social Security Act* (42 USC 1396 *et seq.*), define an **Intermediate Care Facility for Persons with Mental Retardation (ICFs-MR)** as an institution or a distinct part of a facility other than an ICF-MR, that:

- Has the primary purpose of providing "health or rehabilitative services to persons with mental retardation or persons with related conditions,"
- Meets certain standards specified by federal regulations (42 CFR 483.400, subpart I *et seq.*),
- Has been certified to meet additional requirements (42 CFR 442.100, subpart C) as evidenced by a valid agreement between the state Medicaid agency and the facility,
- Fully meets the requirements for a state license to provide services that are above the level of room and board, and
- Provides "active treatment" to all individuals served and for whom payment is requested (42 CFR 483.440).

Active treatment is federally defined as "aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services...". Its goals must be to help the individual (1) acquire the essential skills or behaviors that enable him or her to function as independently as possible and (2) prevent or slow the loss of current "optimal functional status." Regulations require active treatment to include:

- A comprehensive functional assessment by an interdisciplinary team that includes an individual's developmental strengths and preferences, specific functional and adaptive social skills which need to be acquired, presenting disabilities and their causes when possible, and service needs without regard to availability;

- An Individual Program Plan (IPP) that describes opportunities for individual choice and self-management, measurable outcomes to be achieved, and specific specialized and generic strategies, supports, and techniques to be implemented;
- Individualized services or interventions provided in a continuous active treatment program “in sufficient intensity and frequency to support achievement of IPP objectives”;
- Documentation of accurate, systematic, behaviorally stated data about individual performance toward meeting IPP goals as the basis for program changes; and
- Review and update of the functional assessment and IPP by the interdisciplinary team at least annually or as indicated by the individual’s circumstances.

The **Centers for Medicare and Medicaid Services (CMS)**, an agency of the U.S. Department of Health and Human Services, is authorized to certify ICFs-MR, to establish the detailed minimal requirements under which they operate, to monitor their compliance with those requirements, and to set penalties for noncompliance. Federal regulations require that, once a state has chosen to fund services in an ICF-MR, or any other allowable service, as an optional service under Medicaid, the state must continue to cover that service until it has been removed from the state’s annual **Medicaid State Plan**.

Virginia’s Medicaid State Plan has included ICF-MR services for over 30 years, and the state directly owns and operates five ICFs-MR, known as **training centers**, through its **Department of Behavioral Health and Developmental Services (DBHDS)**. Central Virginia Training Center (CVTC) in Amherst County and Southside Virginia Training Center (SVTC) began operation in 1911 and 1939, respectively, although with different functions, services, and names. Southeastern Virginia Training Center (SEVTC), Southwestern Virginia Training Center (SWVTC), and Northern Virginia Training Center (NVTC) began operations as ICFs-MR in the mid-1970s.

Historically, many current residents of the state’s training centers were admitted in childhood, adolescence, or early adulthood during the 1960s and 1970s when placement in a state institution was considered to be either the only option or most appropriate option, and their placements were viewed as lifelong or “permanent.” Since 2005, however, DBHDS reports that all five training centers have experienced increased requests for admissions and consultation services for individuals diagnosed with mild or moderate intellectual disability and co-occurring behavioral challenges. To address this, regional efforts have been underway for several years to provide services for these individuals through collaborations by the training centers, state psychiatric hospitals, and Community Services Boards. As a part of these efforts, DBHDS has identified the need for expansion of specialized residential units and consultation services for communities similar to the Pathways program discussed later in this chapter.

The majority of ICFs-MR statewide are owned and operated by public agencies such as Community Services Boards or by private nonprofit or for-profit organizations. These facilities,

referenced in this assessment as “**community ICFs-MR**,” are licensed by DBHDS and defined by state regulations (12 VAC 35-105-20) as a service that:

- Is licensed by DBHDS to provide care to individuals diagnosed with mental retardation (intellectual disability) or a developmental disability due to brain injury who do not need “...nursing care, but require more intensive training and supervision than may be available in an assisted living facility or group home,”
- Complies with standards established in Title XIX of the *Social Security Act* and related federal regulations,
- Provides health or rehabilitation services, and
- Provides active treatment to individuals to achieve more independence in functioning and improved quality of life.

Community ICFs-MR are subject to the same minimum federal requirements as the state’s larger training centers. Either directly or by contract, they are required to provide their residents with the same array of medical, health, and rehabilitative therapies as required by those residents’ individual comprehensive functional assessments.

The *Code of Virginia* (32.1-123) defines a **nursing home** as “...any facility or any identifiable component of any facility licensed pursuant to this article in which the primary function is the provision, on a continuing basis, of nursing services and health-related services for the treatment and inpatient care of two or more nonrelated individuals, including facilities known by varying nomenclature or designation such as convalescent homes, skilled nursing facilities or skilled care facilities, intermediate care facilities, extended care facilities and nursing or nursing care facilities.” It further defines a “*certified nursing facility*” as “...any skilled nursing facility, skilled care facility, intermediate care facility, nursing or nursing care facility, or nursing home, whether freestanding or a portion of a freestanding medical care facility, that is certified as a Medicare or Medicaid provider, or both...” under Title XVIII of the national *Social Security Act* (42 USC 1395). Entities exempted from this definition and subsequent provisions of the Code of Virginia (32.1-124 through 136) include institutions licensed by DBHDS, institutions or portions thereof licensed by the State Board of Social Services, nursing homes owned or operated by the federal government, and nursing homes owned or operated by the state unless it is certified as a nursing facility.

Consumer guides published by CMS and by the **Department of Medical Assistance Services (DMAS)**, the state’s Medicaid agency, (www.feddesk.com/freehandbooks/1216-4.pdf and http://dmasva.dmas.virginia.gov/Content_atchs/ltc/ltc-guide_srvcs.pdf, respectively) describe nursing homes as long-term care facilities designed to serve people who are determined to have functional impairments due to aging, an injury, or a prolonged illness or chronic condition and who require nursing, medical care, or other supports and environmental adaptations but do not have adequate community supports. These facilities offer room and board, nursing care 24 hours a day, personal care, supervision, and various therapies and

rehabilitation. As with community ICFs-MR, they may be operated by local public agencies or by private nonprofit and for-profit organizations.

Several major initiatives affecting institutional services and promoting **person-centered practices** have begun recently in Virginia. Person-centered practices promote more effective communication with, not to, individuals to determine what is important to and for them, identify the supports that they need and their desired outcomes, and facilitate their individual control over those supports and outcomes. More detailed descriptions of these practices for individuals with disabilities, their families, caregivers, and service providers can be found at www.dbhds.virginia.gov/ODS-PersonCenteredPractices.htm.

Findings by the **Office of the Inspector General (OIG) for Behavioral Health and Developmental Services** in its 2007 systemic review of Virginia's training centers, discussed in more detail in the monitoring and evaluation section of this chapter, were very critical of direct services at those facilities with respect to both the general lack of opportunities for their clients' self-determination and community inclusion as well as a lack of person-centered practices. Since 2008, DBHDS has implemented a system-wide, ongoing training program, **Person-Centered Virginia**, which addresses these issues and, since July 2009, the training centers have implemented Person-Centered Plans as part of the treatment planning process. Nonetheless, the OIG still identifies many of its 2007 findings as active and continues to monitor training center progress in these areas.

Advancing Excellence in America's Nursing Homes (www.nhqualitycampaign.org) is a "culture change" initiative started in 2006 by various national organizations including CMS and the American Health Care Association. It promotes improvements in both the quality of care and the quality of life for individuals served in nursing homes, encouraging those facilities to design environments and adopt person-centered and individualized practices.

In 2010, DMAS developed and implemented **Virginia Gold**, in collaboration with other state agencies, long-term care providers, and stakeholders, to improve the quality of care in nursing homes by increasing retention of Certified Nursing Assistants (CNAs) through better employee benefits, workforce models, and organizational practices. Virginia Gold pilot projects involving five nursing facility grantees run through August 2011 and feature enhanced staff orientations, peer mentoring, coaching supervision, staff rewards and recognition, and training. Each grantee has a work plan with objectives; tracks the monthly number of CNAs employed, the number terminated, and the reasons for termination, such as retirement, resignation, or dismissal for cause; and must submit reports on project activities, their results, and progress toward meeting program objectives.

Effective October 1, 2010, to ensure that individuals reside in the "least restrictive environment," CMS requires new elements in the comprehensive assessment of each potential or current nursing home resident that occurs at admission, annually, and whenever there is a significant change in a resident's status. This **Return to Community Referral Assessment** requirement is designed to ensure that individuals receive information about community living

options when requested and that appropriate planning for transition occurs if the individual wishes to return to the community. Additional information on this requirement is detailed in later sections of this chapter and is available at www.olmsteadva.com/mfp/MDS3SectionQ.htm or www.cms.gov/CommunityServices/10_CommunityLivingInitiative.asp#TopOfPage.

In a related effort to shift the balance of its system from institutional to community-based services, the Commonwealth received \$28 million in federal funding beginning in July 2008 for a **Money Follows the Person (MFP)** demonstration project. With these funds, Virginia planned to facilitate the transition of 1,041 individuals who are elderly (325) or have intellectual or other developmental disabilities (358 each) and currently receiving services in institutions, such as nursing homes, ICFs-MR, and long-stay hospitals, back to community settings of their choice during state fiscal years (SFY) 2009 through 2011. To do so, the state's MFP project enriched services provided under several of the Medicaid Home and Community Based Services (HCBS) Waivers and, through trained staff at Transition Coordination agencies, developed and implemented transition plans that supported individuals' housing and transportation needs.

As experienced in other states and noted in the Kaiser Commission's *MFP: 2010 Snapshot*, Virginia's project start-up and its number of transitions has been much slower than expected. Causes for this slow progress have included delays in the development and approval of operational protocols, outreach to institutions, and the recruitment and training of Transition Coordinators as well as the lack of affordable, accessible housing, stressed state resources for necessary activities, and the amount of time needed to arrange appropriate community services.

The following table shows Virginia's progress at the time of this assessment toward meeting its initial goal of transitioning 1,041 individuals from institutions to community settings by the end of federal fiscal year (FFY) 2011, as reported by the MFP Coordinator at the Department of Medical Assistance Services (DMAS).

PROGRESS TO-DATE IN VIRGINIA'S MFP DEMONSTRATION PROJECT

<u>Date of Count</u>	Total	Transitioned		Plans in Development	
	Enrollees	Number	Percent	Number	Percent
September 3, 2009	95	57	60%	38	40%
June 30, 2010	182	136	75%	46	25%
February 28, 2011	289	204	71%	85	29%

Source: Department of Medical Assistance Services (DMAS).

Originally a four-year initiative, the CMS extended MFP for four more years. To strengthen the program and address the issues being faced by Virginia and other states, CMS made program changes and approved additional funding effective in June 2011. All MFP participants must still meet eligibility criteria for Medicaid HCBS Waivers at time of discharge; however, the original MFP eligibility requirement that an individual be resident in an institution for six consecutive months was reduced to three months. Additional administrative funding received by Virginia is to be used add several new positions at DMAS and the Department of

Behavioral Health and Developmental Services (DBHDS) focusing on discharge planning, housing, and transition.

Despite these efforts, the Commonwealth clearly has a very long way to go in rebalancing and reforming its service system for individuals with disabilities. A major annual report, *The State of the States in Developmental Disabilities*, has consistently ranked Virginia near the bottom among the states and the District of Columbia for its spending on behalf of individuals with intellectual and other developmental disabilities. In 2006 and 2009, Virginia ranked 45th in the nation for its overall fiscal effort, defined as total spending for community services and publicly or privately operated institutions other than nursing facilities per \$1,000 of total state personal income. When the report looked only at state spending for community-based services, however, Virginia's ranking improved slightly from 46th in 2006 to 43rd in 2009.

As noted above, DBHDS has been working to improve person-centered practices that promote self-determination at the state's training centers. It has also been working with stakeholders through various initiatives to change the state's current service system and reduce its reliance on institutional services to one that supports community integration for all individuals with intellectual and developmental disabilities, including those with the most significant disabilities. In addition, since entering office in 2010, the administration of Governor Bob McDonnell has expressed a strong commitment to reduce Virginia's reliance on institutional services, specifically its state-operated training centers.

Creating Opportunities: A Plan for Advancing Community-Focused Services in Virginia, a new strategy implemented by DBHDS in 2010, sets forth an agenda and related initiatives for the next three years to enhance the service system so that it will "...promote self-determination, empowerment... health, and the highest possible level of participation by individuals receiving services in all aspects of community life." Implementation teams are working to develop specific action steps, outcomes, and timelines for each strategic initiative. For developmental disability services, they include building community service capacity, addressing housing needs, creating employment opportunities, and strengthening case management and support coordination capability.

DBHDS plans further downsizing of the state's training centers, and in his presentation to legislative committees in January 2011, its Commissioner observed a significant shift, "Families are no longer selecting training centers." DBHDS' 2010 annual report to the General Assembly calls for a reduction of 57 beds, resulting in estimated annual savings of \$10 million. Closing one unit at Central Virginia Training Center (CVTC) would save another \$1.2 million.

Adverse findings by the **U.S. Department of Justice (DOJ)** are likely to result in additional changes at the training centers. The national *Civil Rights of Institutionalized Persons Act (CRIPA, 42 USC 1997 et seq.)* authorizes DOJ to seek remedies for a pattern or practice that violates the constitutional or federal statutory rights of institutionalized individuals, and in 2008, DOJ began an investigation of services at CVTC. It later expanded that investigation to include examination of whether individuals at that facility as well as those already discharged from it

were being served in the most integrated settings appropriate to their needs and examination of state policies, procedures, and practices regarding admissions and discharges by all training centers. The investigation included extensive, system-wide interviews with DBHDS leadership, CVTC staff and residents, community providers, directors of Community Services Boards (CSBs), and individuals discharged from CVTC to localities throughout the state. On February 10, 2011, the Commonwealth received a letter from DOJ reporting on its completed investigation (www.governor.virginia.gov/news/viewRelease.cfm?id=606) containing a summary of facts supporting its findings and identifying "...minimum steps necessary to remedy the deficiencies."

Federal regulations restrict the use of restraints to emergency situations and only for the length of time required for the emergency to be resolved; however, DOJ sharply criticized CVTC for using restraints as part of individual treatment plans and as an intervention of first, rather than last, resort. It further found that CVTC failed to provide for "reasonable care and safety," as evidenced by:

"...repeated accidents and injuries, inadequate behavioral and psychiatric interventions, and inadequate physical and nutritional management supports. An overarching cause of these harms is CVTC's failure to identify individuals' needs, identify root causes of bad outcomes, and respond to prevent their recurrence. ...Particularly concerning during our initial tours in 2008-09 was CVTC's use of restraints."

DOJ concluded that Virginia had failed systematically to "...provide services to individuals with intellectual and developmental disabilities in the most integrated setting appropriate to their needs in violation of the ADA" (*Americans with Disabilities Act*, 42 U.S.C. 12101 *et seq.*) and that these deficiencies "...have resulted in needless and prolonged institutionalization of, and other harms to, individuals in CVTC and other segregated training centers" in violation of their civil rights. Specifically, DOJ found that the state:

- Fails to develop a sufficient quantity of community-based alternatives for individuals now served at all training centers, especially those with complex needs;
- Fails to use resources already available, such as the Money Follows the Person (MFP) project and Medicaid Home and Community Based Services (HCBS) Waivers to expand community-based services; and
- Places individuals with intellectual and developmental disabilities now in the community at risk of unnecessary institutionalization at state training centers by (a) failing to develop sufficient quantity of community services, including respite and crisis services to prevent admission when they experience crises, and (b) failing to develop a sufficient quantity of community services, especially HCBS Waiver slots, to maintain community life and to prevent admission to state training centers.

In its findings, DOJ complimented the Commonwealth's acknowledgement of the problems and willingness to work toward an amicable solution. It was pleased by the state's

recent “down-payment” of \$30 million to improve services for individuals with intellectual and other disabilities. These funds proposed by the Governor and approved by the 2011 General Assembly comprise a **Behavioral Health and Developmental Services Trust Fund** to be used to provide or improve community-based services, including new Medicaid HCBS Waivers to transition individuals from state training centers to community settings. Other, related budget proposals for state fiscal year (SFY) 2012 approved by the legislature (and covered further in the Medicaid and Community Supports chapters of this assessment) included:

- \$400,000 for five new DBHDS positions to assist individuals served at the training centers and their families in planning for transition to community settings,
- Restoration of \$7.1 million in previous cuts to improve staffing ratios, and
- \$200,000 for DBHDS to contract with consultants for staff training.

Since March 2011, the Governor and Attorney General of Virginia, with collaboration by DBHDS, DMAS, and other relevant parties, have been in negotiation with DOJ to determine how the state will resolve the deficiencies identified by its investigation, and a settlement agreement is expected to be signed by the summer of 2011. If, however, DOJ determines that a resolution of its concerns is not possible, then the U.S. Attorney General may initiate a lawsuit pursuant to CRIPA and ADA under the latter statute’s “Olmstead” integration mandate.

B. Eligibility for Institutional Services

State-Operated Training Centers (ICFs-MR): As required by the *Code of Virginia* (37.2-505), referral for potential admission to one of the state’s five training centers, operated by the Department of Behavioral Health and Developmental Services (DBHDS) as intermediate care facilities for persons with mental retardation (ICFs-MR), is the responsibility of local **Community Services Boards or Behavioral Health Authorities** (jointly referred to as **CSBs**). Details of this face-to-face screening process, conducted by the CSB for the jurisdiction where an individual lives, are detailed later in this chapter.

Eligibility for training center admission is the same as for the Medicaid Home and Community Based Services (HCBS) Intellectual Disability (ID) Waiver. An applicant must have a primary diagnosis of mental retardation (while the preferred term “intellectual disability” is used throughout this assessment, “mental retardation” remains the statutory designation), as determined by a formal assessment by a licensed, qualified professional, and must meet the level-of-functioning requirements for an ICF-MR. The *Virginia Administrative Code* (12 VAC-34-190-10) defines the diagnosis criteria as onset prior to age 18 of significantly sub-average intellectual function, as demonstrated by performance on a standardized measure of intellectual functioning administered in conformity with accepted practice, and concurrent significant limitations in adaptive behavior, as expressed in conceptual, social, and practical adaptive skills.

For regular admission (12 VAC 35-190-30), an individual must also be judicially certified as needing training center services, the center must be the least restrictive environment

that meets the individual's needs, and the training center serving the jurisdiction where the individual lives must have available space and service capacity to meet those needs.

Most individuals admitted to and residing in a state training center have one or more significant disabilities in addition to an intellectual disability. Many have a concurrent visual or hearing impairment, ambulation difficulties, a neurological disorder, neuro-behavioral issues, or a mental illness. Both the 2008-2014 and 2010-2016 DBHDS *Comprehensive State Plans* (www.dbhds.virginia.gov) identify two distinct populations served at the training centers: individuals diagnosed with severe or profound intellectual disability and co-occurring complex medical or physical conditions, such as cerebral palsy, and “dually” diagnosed individuals with an intellectual disability and co-occurring mental illness who have challenging behaviors.

Community ICFs-MR: As described above for the state's training centers, eligibility for admission to a publicly or privately operated community intermediate care facility for persons with mental retardation (ICF-MR) is based on state regulations. An applicant must have a primary diagnosis of intellectual disability, meet ICF-MR level-of-functioning requirements, and be screened by a professional regarding the appropriateness for the residence. Individuals must also have Medicaid or Medicare public insurance, private insurance, or the ability to pay for care directly.

Nursing Facilities (Nursing Homes): As detailed in *A Guide for Long-Term Care Services in Virginia* by the Department of Medical Assistance Services (DMAS), admissions to one of these facilities may occur when an individual:

- Cannot care for personal needs and requires more care than his or her family or loved ones can or is willing to provide,
- Has extensive or complex medical conditions that may be unstable or has the potential for instability,
- Has been recommended for nursing facility placement by his or her physician,
- Has a medical condition that requires observation and assessment to assure evaluation of needs due to an inability for self-observation or self-evaluation, or
- Lacks adequate supports and resources, including environmental adaptation for functional needs, to ensure his or her health and safety.

To be admitted, individuals must be determined to have both functional needs and nursing or other medical needs based on the results of a formal, standardized assessment by a health care professional. As noted in this chapter's introduction, the federal Centers for Medicare and Medicaid (CMS) made important changes to this process that took effect on October 1, 2010. CMS now requires new elements in the comprehensive assessments of potential or current nursing facility residents that occur at admission, annually, or whenever there is a significant change in a resident's status. This **Return to Community Referral Assessment** features additional resident interview items, including a specific question about whether the individual is interested in speaking with someone about the possibility of moving out of the

nursing facility and back into the community. If the individual requests such information, CMS guidelines require the nursing facility to initiate care planning to provide it. This does not commit the individual to a move, but guarantees that he or she will receive information about doing so.

If the individual does want to move to the community and has transition needs that the facility cannot plan for or provide, the facility must make a referral to an appropriate community resource. The community agency then serves as the initial point of contact to provide residents with introductory information about community resources, and collaborates with the nursing facility to make arrangements for transition to community living. In either instance, the nursing home is still responsible for development and documentation of the discharge according to CMS regulations. Based on CMS guidance, Virginia has designated Area Agencies on Aging (AAAs) to serve as the local contact agency (LCA) with the primary, but not exclusive, role for information and technical assistance for nursing facility transition. Other public or private entities, including Centers for Independent Living (CILs), can and do also provide this information and assistance.

Additional information on nursing facility assessment processes and planning for transition to community residence appears in later sections of this chapter.

C. Access to and Delivery of Institutional Services

State-Operated Training Centers (ICFs-MR): Two distinct categories of training center admissions are authorized under the *Code of Virginia* (37.2-805 through 807): **temporary admissions** due to emergencies or for respite care and **judicial certification of eligibility**, commonly referred to as “regular admission.” Regulations (12 VAC 200-20 and 200-30) vary for the two types of admissions, such as time limitations for temporary admissions. To protect an individual’s rights, stays longer than the limits set for temporary admissions require judicial certification.

As noted above, state law requires **Community Services Boards (CSBs)** to provide prescreening services for all individuals referred for potential admission to a training center. Responsibility for prescreening is assigned to the CSB that serves the city or county where an individual resides or, if the individual is a minor, where his or her parent or guardian resides or to the CSB that provides an individual with case management. An individual, or his or her parents, guardian, or authorized representative if appropriate, must contact the CSB to start the admissions process. If an individual is not able to make necessary decisions regarding his or her admission or treatment and there are no family members available to do so, the CSB will conduct a capacity evaluation and assist in finding an authorized representative.

For all admission requests, a **CSB Support Coordinator**, also referred to as a **case manager**, must conduct a face-to-face interview with the individual and complete a preadmission screening report. This report includes a standardized application form; information

on the individual's medical history, current medical conditions, and medications; housing or living arrangements, natural supports, and social history; an Individualized Education Plan (IEP) for school-aged children and youth up to age 22 or a vocational assessment for adults, as appropriate; and a discharge plan that states the services to be provided upon discharge and its anticipated date. A formal evaluation by a qualified, licensed psychologist must be available or obtained to verify the individual's diagnosis of intellectual disability (mental retardation) and current level of cognitive functioning. In addition, the case manager must conduct a **Level of Functioning (LOF) Survey** that assesses the individual's strengths and weaknesses in adaptive functioning and in activities of daily living to determine whether he or she meets the level of functioning requirement for an intermediate care facility for persons with mental retardation (ICF-MR) placement or Medicaid Home and Community Based Services (HCBS) Waiver.

Based on this information, the case manager must determine if community services and supports are available to meet the individual's needs and, if so, inform the individual and his parents, guardian, or authorized representative, if appropriate, that community services are a potential option. Once individuals and their parents, guardians, or authorized representatives, if appropriate, have been fully informed of their options, the individuals or their parents, guardians, or authorized representatives, if appropriate, must sign a written declaration of their "choice" of services, including, but not limited to, placement in a training center. It is current CSB practice that admission to a training center is initiated only after community options have been exhausted.

If admission to a training center is chosen as an option, the CSB case manager forwards the completed written prescreening report to the executive director, or designee, of the training center serving the geographic area in which the individual resides for review and determination of whether admission is appropriate for that individual. A response must be returned to the CSB within ten days, and upon receipt, the CSB notifies the individual and his parents, guardian, or authorized representative, if applicable, of the determination.

Once the training center and CSB staff have determined that the individual is eligible for **regular admission** to a training center, state regulations (12 VAC 35-190-51 *et seq.*) authorize the CSB or a parent, guardian, or authorized representative of that individual to initiate judicial proceedings to certify that legal eligibility requirements (37.2-806) for admission have been met. The individual must be present at any hearing, have an opportunity to prepare his or her defense, if any, and have an attorney present on his or her behalf. A judge or special justice may request that a physician, licensed psychologist, or the CSB case manager who assessed the individual attend the proceeding and certify that an assessment was conducted within 30 days of the proceeding and certify its findings relevant to admissions criteria. Based on the information obtained and observation of the individual, the judge or special justice may authorize the parent, guardian, or authorized representative of the individual to admit the individual to a training center and authorize the appropriate facility to accept the individual. It must be emphasized that this judicial certification is not an involuntary admission, and the individual has the right to appeal the admission order to the Circuit Court.

Both emergency and respite care **temporary admissions** are intended to be of short duration, and neither involves a judicial certification of eligibility unless the individual's stay

extends past the limits set by state law of 21 consecutive days or a total of 75 days in any calendar year. An emergency admission means a “temporary acceptance” into a training center “when immediate care is necessary and no other community alternatives are available.” A respite care admission is specifically intended to “provide temporary, substitute care for that which normally provided by the primary caregiver.” Respite admissions may be sought because the individual’s primary caregiver has been hospitalized or needs periodic relief from caregiving.

DBHDS reports that, at the time of this assessment, almost all of the individuals admitted to and residing in the state’s training centers are adults. Southeastern and Southwestern Virginia Training Centers (SEVTC and SWVTC) have a children’s residential services license from DBHDS to serve small numbers of youth, ages eight through 17 at SEVTC and ages 12 through 21 at SWVTC. Youth admitted to these two facilities typically have a dual diagnosis of intellectual disability and mental illness, and these facilities are considered to be “providers of last resort” for these age groups. In addition to its certified ICF-MR units for adults with intellectual disabilities, Central Virginia Training Center (CVTC) has certified nursing units which can accommodate up a total of 104 residents.

The 2010-2016 DBHDS *Comprehensive State Plan* provides a more detailed snapshot of the average ages for training center residents and the average lengths of their stays for episodes of care. In state fiscal year (SFY) 2009, only two percent of all training center residents were below age 22, while eight percent were over age 65, and the average age of residents has risen slowly over recent years from 47 in SFY 2005 to 47.7 in SFY 2007 to 48 in SFY 2009. DBHDS attributes this increase to the long lengths of stay for many residents, a lack of community providers to support the aging population of persons with intellectual disabilities, the need for community residential programs that support individuals who require tube feeding, and the complex medical needs of many training center residents.

The following table compares the age distribution of training center residents at the end of selected recent state fiscal years (SFY), including both residents of the certified nursing units at CVTC and residents of ICF-MR certified units at all of the training centers. Counts reflect all individuals “on-books” at the end of each state fiscal year, June 30, and the amount and percent of change is for the entire period shown. On-books refers to all persons admitted to a facility, but not yet discharged, and includes any who were off-campus on a pass or on leave.

STATE TRAINING CENTER RESIDENTS BY AGE

Age Category	SFY 2005	SFY 2007	SFY 2010	Change	Percent
0-5 years	0	0	0	0	----
6-15 years	4	5	1	-3	-75%
16-21 years	4	11	6	+2	+50%
22-54 years	1,039	965	722	-317	-31%
55-64 years	299	267	295	-4	-1%
65 years or older	170	139	136	-34	-20%
Total	1,516	1,387	1,160	-356	-23%

Source: Department of Behavioral Health and Developmental Services (DBHDS).

Overall, the number of residents declined by more than 23 percent from SFY 2005 to SFY 2010, with most of that decline coming in residents ages 22 through 54 (317 fewer, minus 31 percent) and ages 65 and older (34 fewer, minus 20 percent). For all three years, individuals ages 22 through 54 comprised the greatest proportion of residents, 62 percent at the end of SFY 2010. Individuals ages 55 through 64 made up the second largest sub-population, 25 percent for that same year. Those ages 65 and over comprised 12 percent, and those ages 21 and younger, less than one percent at that time.

The next table shows the total number of admissions to all state training centers by admissions category for those same years as well as the amount of change for the entire period.

STATE TRAINING CENTER ADMISSIONS BY TYPE

Admissions Type	SFY 2005	SFY 2007	SFY 2010	Change	Percent
Judicial Certification	107	23	12	-95	-89%
Emergency	38	53	37	-1	-3%
Respite Care	41	60	59	+18	+44%
Total	186	136	108	-78	-42%

Source: Department of Behavioral Health and Developmental Services (DBHDS).

The significant decline in admissions indicated above, 42 percent from SFY 2005 to SFY 2010, is primarily due to an even more substantial decrease in judicial certification, or regular, admissions of 89 percent, with most of that decline occurring between SFY 2005 and SFY 2007. The overall decline in total admissions was moderated by an increase in emergency admissions between SFY 2005 and SFY 2007 before returning to the earlier level by SFY 2010 and by respite care admissions, which declined considerably between SFY 2005 and SFY 2007 then were essentially stable between SFY 2007 and SFY 2010. DBHDS reports that the overall drop in admissions, driven by the decline in regular admissions, has resulted from the department and its CSB partners making a concerted effort, as required by state regulations, to ensure that all community alternatives have been exhausted prior to making a request for a regular admission.

Additional procedural guidelines for both the CSBs and training centers, entitled *Admissions and Discharge Protocols for Individuals with Intellectual Disabilities*, provide detailed information on the specific roles and responsibilities for each entity during the admission and discharge processes based on statutory requirements as well as the Community Services Performance Contract between DBHDS and the CSBs. These protocols help to ensure consistency and improve continuity of services statewide for individuals referred to or served at the training centers. In 2010, DBHDS staff and representatives from the CSBs and the Virginia Office for Protection and Advocacy (VOPA) met to review and revise the protocols. The revised protocols were adopted and implemented on March 1, 2011, and are posted on the DBHDS website (www.dbhds.virginia.gov/documents/ODS/ods-Admission-Discharge-Protocol.pdf).

An **admission appeal** is possible when any admission request is denied. A Training center's director must provide a written statement of the reason or reasons for the denial and may

also provide recommendations for alternative services. If the parent, guardian, or authorized representative, as applicable, for the individual denied admission disagrees with this decision, either that person or the CSB representative may submit a written request for reconsideration of the decision by the DBHDS Commissioner within ten days of receiving the decision notice.

Procedural variations exist in **treatment and discharge planning** by type of admission. For regular admissions, state law (37.2-806) specifies that an individual must receive active treatment, throughout his or her stay at a training center, based on an “individualized habilitation plan” describing the services that will be provided to meet the individual’s needs as identified by assessment. Within 30 days of admission, an interdisciplinary team must collaborate with CSB staff to develop this plan, referred to by DBHDS as an **Individualized Support Plan (ISP)**. The ISP must include supports toward a discharge plan as well as input from the individual, his or her family members, guardian, or authorized representative, if applicable, and the CSB. To facilitate the participation of external participants, meetings may be conducted using teleconferencing or video-conferencing, if necessary.

Since May 2009, as a part of the ISP process, all training centers have been phasing in implementation of the **Supports Intensity Scale (SIS)**. Developed by the American Association for Intellectual and Developmental Disabilities (AAIDD), this standardized assessment measures the pattern and intensity of supports needed by persons with intellectual and developmental disabilities to be successful. It will be administered every three years for each resident and is currently the only available assessment instrument for this population that measures the frequency and level of support needs rather than an individual’s “deficits.”

Using information from the SIS and other assessments, an individual’s interdisciplinary team must review his or her progress at 30, 60, 90, and 180 days following regular admission to a training center. Thereafter, team reviews are conducted annually or whenever circumstances warrant. A Qualified Mental Retardation Professional (QMRP), or Service Coordinator, who works with the individual must also conduct quarterly reviews. Whenever an annual or special review identifies a change in an individual’s status, such as medical issues, that would significantly affect that individual’s discharge potential, statutes require that training center staff collaborate with the CSB to ensure that the individual’s CSB Support Coordinator (case manager) is informed of any changes in the services or supports needed for the individual’s discharge plan.

The *Code of Virginia* (37.2-505) requires that this discharge plan developed at the initial meeting of an individual’s interdisciplinary team, in consultation with training center staff and the individual’s CSB Support Coordinator, include the following information:

- The anticipated date of discharge from the training center;
- A description of all the services and supports needed for the individual’s successful return to and life in the community, such as psychiatric, social, educational, medical, housing, employment, legal, advocacy, transportation, and others as indicated; and
- The specific public and private providers who agree to supply these needed services, consistent with the right of the individual or his or her parents, guardian, or authorized representative, if applicable, to choose his or her own providers.

The table below shows the **operational capacity** for Virginia's training centers near the end of selected state fiscal years (SFY) and the overall change from 2005 to 2010. Annual dates are not consistent due to data system limitations. Operational beds are those for which a facility is funded for staff and services. Counts for CVTC include both the beds in its certified ICF-MR, nursing facility, and acute care units. The CVTC acute care beds were closed as of July 1, 2010.

OPERATIONAL CAPACITY (BEDS) AT VIRGINIA TRAINING CENTERS

Virginia Training Center	June 30, 2005	July 5, 2007	July 9, 2009	July 1, 2010	Change	Percent
Central (CVTC)	611	577	558	510	-101	-16.5%
Northern (NVTC)	200	200	200	200	0	0.0%
Southeastern (SEVTC)	200	200	200	200	0	0.0%
Southside (SVTC)	395	359	361	307	-88	-22.3%
Southwestern (SWVTC)	223	215	210	210	-13	-5.8%
Total	1,629	1,551	1,529	1,427	-202	-12.4%

Sources: Department of Behavioral Health and Developmental Services (DBHDS). *Comprehensive State Plans* for 2006-2012, 2008-2014, and 2010-2016, and DBHDS Office of Developmental Services.

As the table shows, the total number of operational beds at all training centers decreased 12.4 percent, from 1,629 at the end of SFY 2005 to 1,427 at the end of SFY 2010. While three training centers, CVTC, SVTC, and SWVTC, experienced declines, most of the reduction occurred at CVTC, which dropped by 16.5 percent, and SVTC, which dropped by 22.3 percent. SWVTC, which experienced a drop of 5.8 percent between SFY 2005 and SFY 2009, saw no decline for SFY 2010.

Average Daily Census (ADC) reflects the *average* number of residents on-books, including those on pass or leave, at a facility over a period of time, usually the state fiscal year. ADC and residents' length of stay are important factors affecting the availability of admissions at state training centers. The next table shows the ADC for selected years between SFY 2005 and SFY 2010 as well as the change for that entire period.

AVERAGE DAILY CENSUS (ADC) AT VIRGINIA TRAINING CENTERS

Training Center	SFY 2005	SFY 2007	SFY 2010	Change	Percent
Central (CVTC)	556	509	400	-156	-28.1%
Northern (NVTC)	194	172	166	-28	-14.4%
Southeastern (SEVTC)	181	187	145	-36	-19.9%
Southside (SVTC)	346	311	265	-81	-23.4%
Southwestern (SWVTC)	216	209	194	-22	-10.2%
Total	1,493	1,388	1,170	-323	-21.6%

Source: Department of Behavioral Health and Developmental Services (DBHDS).

During this period, ADC declined for all state training centers by 21.6 percent at a rate of approximately 66 individuals per year, a total of 323 individuals from SFY 2005 to 2010. All of

the training centers experienced a decline, with the largest decreases in numbers and percent occurring at CVTC (156, or 28.1 percent) and SVTC (81, or 23.4 percent). The population at SEVTC declined by nearly 20 percent, mostly after SFY 2007, reflecting the downsizing effort as a replacement facility with only 75 beds is being constructed. Declines at CVTC also accelerated from 47 (8.5 percent) between SFY 2005 and 2007 to 109 (21.4 percent) between SFY 2007 and 2010. In contrast, the ADC at NVTC fell by 22 individuals (11.3 percent) from 2005 to 2007, then by only 6 (3.5 percent) from 2007 to 2010. SWVTC experienced the lowest decrease for the entire period (10.2 percent).

Since the end of SFY 2010, DBHDS reports, the number of residents at Virginia's training centers has continued to decline, totaling only 1,113 as of December 16, 2010.

DBHDS attributes these census declines to several factors. CSBs, in cooperation with training center staff, have worked to minimize the number of long-term admissions and ensure that all emergency and respite admissions are for less than the regulatory limit of 75 days. They have also increased efforts to find community placements, resulting in more discharges. These reductions in new long-term admissions have contributed to the increase in average age of training center residents noted above, and some of the decline in the ADC can be attributed to deaths of elderly residents due to aging and other natural causes.

According to the DBHDS 2010-2016 *Comprehensive State Plan*, the **average length of stay (ALOS)** for all training residents in SFY 2009 was 28.6 years. For that year, 2.6 percent of episodes of care (38) lasted less than seven days, while 10.1 percent (145) were for more than 50 years. The following table shows ALOS at the end of state fiscal years (SFY) 2005, 2007, and 2010. As before, the averages are based on all residents who were on-books, and the data for 2007 has been updated from what appeared in the 2008 edition of this assessment.

AVERAGE LENGTH OF STAY (ALOS) AT VIRGINIA TRAINING CENTERS

Training Center	Years of Stay		
	SFY 2005	SFY 2007	SFY 2010
Central (CVTC)	38.1	39.6	41.8
Northern (NVTC)	21.9	23.5	25.8
Southeastern (SEVTC)	17.3	18.4	21.3
Southside (SVTC)	28.0	30.0	32.4
Southwestern (SWVTC)	17.8	19.1	21.9

Source: Department of Behavioral Health and Developmental Services (DBHDS), AVATAR database.

As this table shows, the average length of stay for all training centers has been slowly increasing. By the end of SFY 2010, they ranged from 21.3 years at SEVTC to 41.8 years at CVTC. The variation in ALOS among the training centers can be attributed, in part, to differences in their duration of operation. As described earlier, NVTC, SEVTC, and SWVTC

began operations in the mid-1970s, while CVTC and SVTC have operated since 1911 and 1939, respectively; although not as ICFs-MR for that entire time.

Institutional trends across the United States provide useful benchmarks for monitoring progress in Virginia. According to *Residential Services for Persons with Developmental Disabilities: Status and Trends*, an annual national report, nine states had closed all of their large state-operated institutions for individuals with intellectual or developmental disabilities (ID/DD) by June 30, 2009. Virginia is now one of only ten states that have not close any state-operated institutions for this population. The report further noted that only 0.6 percent of all persons with ID/DD receiving services nationally lived in residences with 16 or more beds.

Another national trend has been the substantial shift to small community-based, non-state-operated residential services. By the end of federal fiscal year (FFY) 2009, only 1.3 percent of all residential settings for individuals with ID/DD were state-operated. In addition, during the past decade, several states have significantly decreased their number of community intermediate care facilities for persons with mental retardation (ICFs-MR) by converting them to small residences of six or fewer residents receiving services and supports through Medicaid Home and Community Based Services (HCBS) Waivers. Alaska no longer has any ICFs-MR, and 20 states have fewer than ten each, 1.1 percent of the total nationally.

In 2005, the Virginia Department of Behavioral Health and Developmental Services, under its former agency name, produced a legislative report, *House Document #76: The Cost and Feasibility of Alternatives to the State's Five Mental Retardation Training Centers* (www.dbhds.virginia.gov/documents/reports/OMR-HouseDocument76.pdf) that concluded:

“The most feasible, cost-effective option for Virginia is the combination of developing community alternatives, reducing the size of the state training centers by re-focusing their purpose and function, and making needed renovations to these centers necessary for the maintenance of safety standards and increased efficiency.”

This report recommended an overall reduction of 100 individuals per year across all of the state's training centers, from an average census of 1,524 in state fiscal year (SFY) 2005 to 724 by the end of SFY 2012. It emphasized that expansion of the types and capacity of community services and supports was essential to achieving this goal. As noted above, however, the *total* number of residents for all Virginia's training centers on December 16, 2010, was still 1,113.

At the time of this assessment, Virginia has no specific plans to close any of its five training centers, but this could change as a result of the U.S. Department of Justice's investigation findings discussed in the introduction to this chapter. In December 2005, then Governor John Warner proposed an infusion of funding for behavioral health and developmental services that included tens of millions of capital outlay dollars for redesign and rebuilding of Central Virginia Training Center (CVTC) and Southeastern Virginia Training Center (SEVTC).

As a result of extensive public advocacy opposing the rebuilding of these two large institutions, in 2009, his successor, Governor Tim Kaine, proposed the closure of SEVTC. The General Assembly did not agree to this proposed closure and reaffirmed, albeit at a lower dollar amount, the plans to rebuild CVTC and SEVTC.

Subsequently, the 2009 General Assembly allocated \$23 million in General Fund capital outlay funds to construct a replacement facility for SEVTC with 75 beds, as noted earlier, and \$24 million to renovate CVTC at a capacity of 300 beds. In addition, for the first time in Virginia's history, the legislature designated capital outlay funds, in the amount of \$18.4 million, to build community residences, community ICFs-MR and Medicaid HCBS Waiver group homes, as a part of the downsizing of each facility.

In a presentation to the 2011 General Assembly, the DBHDS Commissioner reported that construction on the new 75-bed SEVTC and for the community residences in the surrounding Tidewater area began in late September 2010, with completion of the new SEVTC scheduled for September 2011. Renovations at CVTC have begun on two buildings and, along with planned work on additional buildings at that site, are expected to continue through 2015. As of January 2011, planning for the community residences near CVTC in the greater Lynchburg area was still underway.

Community ICFs-MR: Individuals seeking admission to a non-state-operated community intermediate care facility for persons with mental retardation (ICF-MR) apply directly to the provider organization responsible for the institution's operation. Currently, a number of these ICFs-MR are operated by local Community Services Boards (CSBs) and others are operated by private nonprofit and for-profit entities. Their geographic service areas vary, and each determines its own application and admissions processes. Most ICFs-MR operated by CSBs serve individuals within their own local jurisdictions first, but they can serve individuals from outside of their localities if they choose to do so. Private providers may accept referrals from anywhere in the state. A directory of ICFs-MR, nursing facilities, hospital long-term units, and mental health facilities statewide produced by the Office of Licensure and Certification at the Virginia Department of Health (VDH) is available online at www.vdh.virginia.gov/OLC/Facilities/.

All community ICFs-MR are covered by the same state and federal regulations as the state's training centers. Individuals must receive "all necessary services" appropriate to their individual needs based on an individual assessment, an Individualized Support Plan (ISP) must be developed, and active treatment must be provided according to that plan. Assessments must be conducted regularly to determine and update the individual's service and support needs, as well as to reassess whether the individual continues to need the ICF-MR level of care. Involvement by the individual or his or her parents, guardian, or authorized representative, as appropriate, in treatment planning is required, and involvement by a CSB Support Coordinator is requested. Individuals served in community ICFs-MR must be certified annually to ensure that they are receiving the appropriate level of care. Any transition to another residential and service setting must be planned to ensure continuity of needed services and supports.

The table below contains data provided by the Department of Medical Assistance Services (DMAS) showing the number of individuals served in community ICFs-MR for state fiscal years (SFY) 2007 and 2010 by age groups.

PERSONS SERVED IN COMMUNITY ICFs-MR BY AGE

Age Groups	SFY 2007	SFY 2010
Under 1 year	0	0
1-5 years	8	9
6-14 years	44	44
15-20 years	68	52
Subtotal for Ages 1-20	120	105
21-44 years	111	132
45-64 years	102	137
Subtotal for Ages 21-64	213	269
65-74 years	5	17
75-84 years	2	0
85 & older	0	0
Subtotal for Ages 65 & older	7	17
Total for All Ages	340	391

Source: Department of Medical Assistance Services (DMAS).

In SFY 2010, children and youth ages one through 20 comprised 26.9 percent of all individuals served by community ICFs-MR, and their total number declined by 12.5 percent from SFY 2007. Even though the number of elderly community ICF-MR residents ages 65 and over more than doubled during this time, the proportion of elderly residents remained small at 4.3 percent in SFY 2010. In contrast, adults ages 21 through 64 made up 68.8 percent of community ICF-MR residents in SFY 2010, and their total number increased by 26.3 percent from SFY 2007. Of these adults, those ages 44 through 64 increased at an even higher rate, by 35.0 percent, more than twice the rate of growth for all ages, 15.0 percent.

The state has also experienced growth in the number of community ICFs-MR. The Virginia Department of Health (VDH) reports an increase of 44 percent in recent years, from 25 in SFY 2005 to 21 in SFY 2007 to 36 in SFY 2010. At the end of SFY 2010, community ICFs-MR had a total capacity of 391 beds, an average of 10.9 each. The majority of community ICFs-MR across the state had eight or more beds, with the smallest having four beds and the largest, St. Mary's Home for Disabled Children, a specialized ICF-MR for children and adolescents in Norfolk, having 88. This large number at one facility contributed to the Tidewater region of the state having the largest number of community ICF-MR beds.

Since a single provider may be licensed for and operate more than one community ICF-MR at different locations, the number of providers has grown slightly less than the number of facilities. DMAS maintains data on "enrolled" ICF-MR providers, meaning those approved for Medicaid reimbursement, and such approval first requires licensing by the Department of

Behavioral Health and Developmental Services (DBHDS), which is further contingent on a determination by VDH that the facility meets federal regulations. There were a total of 19 enrolled providers at the end of SFY 2004, 28 at the end of both SFY 2005 and 2006, 30 at the end of SFY 2007, and 33 at the end of SFY 2010. Three of those enrolled in 2007 and 2010 were based out-of-state.

Nursing Facilities (Nursing Homes): State law requires that admission to a nursing facility be based on a formal, face-to-face assessment by a trained, qualified professional. Individuals may be screened while at home or in another community setting or during a treatment stay at an inpatient hospital. Community-based assessments are conducted by a social worker from the local social services department and a nurse from the local health department. Results of their assessments are forwarded to the director of the local health department for a decision on whether nursing care is necessary. In compliance with federal regulations, the state Department of Medical Assistance Services (DMAS) requires pre-screeners to discuss available community service options as well as nursing facility options with the individual being screened.

Screeners conduct their assessment using the **Uniform Assessment Instrument (UAI)**, a standardized, multi-dimensional questionnaire that addresses an individual's social functioning, physical and mental health, medical and nursing needs, and functional abilities. Medical or nursing needs include such things as wound care and assistance in medication administration. Functional ability refers to the degree of assistance that an individual requires to complete daily living activities such as bathing, toileting, or dressing. Based on the information gathered using the UAI, the screener determines the person's care needs, whether he or she meets the criteria for nursing home care, and whether or not he or she will be at risk of nursing home placement if additional assistance is not received.

When UAI screening indicates that an individual may have or does have a diagnosis of an intellectual or other developmental disability (ID/DD) or a serious mental illness, federal regulations require an additional "Level II" evaluation, the **Pre-Admission Screening and Resident Review (PASRR)**, to ensure that a nursing facility is the most appropriate setting to meet both the individual's medical and physical needs and his or her behavioral or psychiatric needs. In Virginia, when ID/DD or a serious mental illness is suspected or known based on the UAI, the local pre-screener sends a report to DMAS and the Department for Behavioral Health and Developmental Services (DBHDS). Staff from these two agencies consult on the findings as indicated, and if a PASRR has not been completed recently, DMAS, as the purchasing agency, will typically request a PASRR evaluation through its contract with Dual Diagnosis Management Ascend (DDM Ascend), a private provider. This evaluation must be completed within five to seven working days of receipt of the UAI assessment. Based on the PASRR findings, DBHDS conducts a Quality Assurance review and advises DMAS on appropriate placement and specialized services needed by the individual. DMAS then determines whether or not a nursing facility is appropriate.

If an individual needs to be assessed during a hospital stay, a hospital social worker or discharge planner typically conducts the UAI evaluation and explains its results. When support

needs are identified, the staff person must describe the long-term care options available, both institutional and community-based. State and federal regulations also require that hospital staff ask the individual about their preference for receiving services. If after receiving this information, an individual chooses to stay in the community, the hospital must make a referral to appropriate community resources

If an individual chooses institutional care, hospital staff should provide him or her with a list of nursing facilities (nursing homes) in the area which have available beds, and in all cases, a nursing home selected by an individual must provide that individual with a written description of services, charges, and fees *before* the individual moves to that facility. Lists of nursing facilities are also available from SeniorNavigator (www.seniornavigator.com) using a search for key words such as nursing home, skilled nursing facility, or nursing facility in a specific geographic area. The information provided will include the number and type of certified beds based on the latest available information from the Virginia Department of Health (VDH).

The *Guide to Choosing a Nursing Home*, a booklet available online from CMS (www.medicare.gov/Publications/Pubs/pdf/02174.pdf), encourages individuals interested in nursing facility care to contact or meet with local AAAs, CILs, or other appropriate community resources to identify all available long-term care options. Quality of care information for making a more informed choice can also be obtained using the Medicare Nursing Home Compare online tool (www.medicare.gov/NHCompare/Home.asp) or by contacting VDH, DMAS, the Virginia Department for the Aging (VDA) Long-Term Care Ombudsman program, or local consumer affairs offices. Comparative site visits to various facilities being considered are also recommended.

Once an individual has entered a nursing facility, a comprehensive plan of care must be developed based on a formal assessment of his or her needs for supervision, assistance with daily living activities, therapy, nursing care, and other related services. This plan includes assessments of the resident's clinical and psychosocial needs, appropriate interventions to meet them, treatment goals, and measures to identify progress in achieving the goals. If the individual received a PASRR evaluation as a part of his or her assessment, the plan must also incorporate its recommendations. A written discharge plan is also required as part of the individual's clinical record and must include the services to be delivered, goals to be achieved, and the post-discharge services needed or final disposition at the time of discharge.

During state fiscal year (SFY) 2010, there were 279 nursing facilities in operation statewide, each unique in its day-to-day operation. Because of staff availability, especially psychiatrists or psychologists, they vary in their capacity to serve individuals with complex needs such as serious mental illness, intellectual disability, or behavioral problems, and as a result, variation exists in the populations that they accept for services. According to DMAS data, most primarily serve individuals ages 65 and over.

The information in the table below, drawn from the comprehensive assessments and a billing records database maintained by DMAS, shows the number of individuals served in

nursing facilities for selected state fiscal years (SFY) between 2004 and 2010 by age category. The overall change for that period is also indicated.

PERSONS SERVED IN NURSING FACILITIES

Age Groups	SFY 2004	SFY 2005	SFY 2006	SFY 2007	SFY 2010	Change
Under 1 year	11	10	1	0	1	-10
1-5 years	17	20	20	16	21	+4
6-14 years	33	33	24	19	38	+5
15-20 years	35	25	21	22	29	-6
Subtotal for Ages 1-20	96	88	66	57	89	-7
21-44 years	779	782	702	676	622	-157
45-64 years	3,297	3,512	3,793	3,884	4,251	+954
Agess 65 & older	23,536	23,347	24,221	24,252	22,588	-948
Total for All Ages	27,708	27,729	28,782	28,869	27,550	-158

Source: Department of Medical Assistance Services (DMAS), Long-Term Care Division.

From SFY 2004 to SFY 2007, the number served in nursing facilities grew annually, increasing by 1,161 individuals (4.2 percent) for that period, then declined by 1,319 individuals (4.6 percent) between SFY 2007 and SFY 2010. During this period, the primary residents of Virginia's nursing facilities were those over age 65, comprising 85 percent of residents in SFY in 2004, 84 percent in SFY 2007, and 82 percent in SFY 2010. The slightly declining proportion of elderly residents reflects the overall reduction of their numbers by 948 individuals (4 percent) from SFY 2004 to SFY 2010 as well as annual increases in the number of adults ages 45 through 64 that have resulted in a gain of 954 individuals (29 percent) between those years. Moreover, after declining from 96 to 57 (41 percent) between SFY 2004 and SFY 2007, the number of children and youth under age 21 increased (56 percent) to 89 in SFY 2010, nearly equaling the number served six years earlier. Children ages six to 14 made up most of this increase.

National data also reflect increasing numbers of non-elderly adults residing in nursing facilities. Recent research at the University of Maryland's Department of Public Policy analyzed data from the annual CMS Nursing Home Data Compendia, and found that, although rates of nursing home residence by adults ages 65 and older decreased in 36 states between 2000 and 2007, rates for adults ages 31 to 64 increased in 48 states, declining only in Alaska and Arizona. The study also found significant variability among the states in their rates of nursing home use by age groups.

Individuals with intellectual or developmental disabilities (ID/DD) are a sub-population served at nursing facilities, and preliminary data from the 2011 edition of the *State of the States in Developmental Disabilities* ranks Virginia as 17th highest among the states in utilization of nursing facilities to serve individuals with ID/DD. While the average utilization rate among all the states was 10.7 individuals per 100,000 of general population, Virginia's rate was 15.1 per 100,000.

Data obtained from DMAS identifies the number of individuals with ID/DD receiving services in nursing facilities as 906 in state fiscal year (SFY) 2010; however, this DMAS database included information from the Uniform Assessment Instruments (UAI)s of only 64.4 percent of the individuals receiving services that year and may be an undercount. Of these individuals, 87.2 percent were ages 45 and older and only 3.1 percent were age 20 or younger. Specifically, this count included one individual between ages one and five, 17 between ages six and 14, ten between ages 15 and 20, 88 between ages 21 and 44, 368 between ages 45 and 64, and 422 aged 65 or older.

Methodologies and disability definitions or categories vary among reports on placement of persons with ID/DD in nursing facilities, making determination of trends difficult. The *State of the States in Developmental Disabilities* national report mentioned above analyzes data collected from both state ID/DD agencies and from the CMS Online Survey, Certification, and Reporting (OSCAR) system. Its most recent analysis indicates that 1,130 Virginians with ID/DD were served in nursing facilities across Virginia in SFY 2004; 1,163 in SFY 2006; and 1,184 in SFY 2009. This reflects a total increase for the period of only 54 individuals (4.8 percent). At the time of this assessment, the 2011 edition of this report is not available online, but the 2008 report can be found at www.cu.edu/ColemanInstitute/stateofthestates. State profiles also available at that website have been updated with 2009 data.

A second source, the annual *Residential Services for Persons with Developmental Disabilities* report by the Institute on Community Integration at the University of Minnesota (<http://rtc.umn.edu/docs/risp2009.pdf>) uses data only from state ID/DD agencies. Data obtained for its 2010 edition from the Virginia Department of Behavioral Health and Developmental Services (DBHDS) covers only individuals with intellectual disabilities (ID) served in nursing facilities for SFY 2004 (460) and SFY 2006 (899), but includes individuals with intellectual or other developmental disabilities (ID/DD) for SFY 2008 (2,823) and SFY 2009 (2,877). This change in the data provided by DBHDS reflected its recently expanded mission to include coordination and planning for other developmental disabilities in addition to its existing responsibilities for intellectual disabilities.

In tracking nursing home utilization, the national Centers for Medicare and Medicaid Services (CMS) uses the broader federal population category of “blind or disabled” that includes individuals with acquired disabilities in addition to those with ID/DD. The number of individuals in this category grew by 18 percent (772) from SFY 2004 (4,276) to SFY 2007 (5,048) and by another 14 percent (711) by SFY 2010 (5,759). The proportion of the population served in nursing homes who are blind or disabled has also increased over this time, from 15 percent in SFY 2004 to 17.5 percent in SFY 2007 then 20.9 percent in SFY 2010.

D. Available Institutional Services

The facilities covered below are required by federal and state regulations to provide or to obtain a full range of appropriate medical, health, and rehabilitative services to meet the needs

identified by formal assessment of the individuals whom they serve. Core services, which may be provided either directly or by contract, include physical, occupational, and recreational therapy; speech pathology; and nutritional, medical, dental, pharmaceutical, psychological, and social services. Intermediate care facilities for persons with mental retardation (ICFs-MR), either state-operated training centers or community ICFs-MR, may also provide vocational training, as appropriate.

State-Operated Training Centers (ICFs-MR): The stated goal for the state's training centers, as for all intermediate care facilities for persons with mental retardation (ICFs-MR), is to provide highly individualized services in the least intrusive and restrictive manner possible, subject to the realities of life in such large facilities. Although long-term admissions have historically been their main function, training centers also provide short-term respite and emergency stays, and their operator, the Department of Behavioral Health and Developmental Services (DBHDS) has promoted short-term stays, such as for behavioral management and intervention, as a new model of service. In addition to providing ICF-MR services, one of these five facilities, Central Virginia Training Center (CVTC) near Lynchburg, also operates certified skilled nursing units.

Over the past decade, in addition to the core services mentioned above, each of the state's training centers has been charged with directly providing or contracting with private clinicians to provide services and specialized supports on an outpatient basis through **Regional Community Support Centers (RCSC)**. These centers are intended to serve individuals with intellectual disabilities living in nearby communities who are referred for services by their local Community Services Boards (CSBs). Services provided through the RCSCs vary somewhat depending on regional needs and priorities. During state fiscal year (SFY) 2010, they included psychological or behavioral consultations and testing; multiple dental procedures; laboratory, medical, and preventative services; pediatric neurology; nursing and nutritional consultation; physical therapy; rehabilitative engineering; speech and language therapies; therapeutic recreation; and autism support groups. RCSC's also provided training for staff of community provider agencies.

In August 2003, Southwestern Virginia Training Center (SWVTC) opened its **Pathways Program** to serve individuals with intellectual disabilities and a concurrent diagnosis of mental illness or complex behaviors who live in the community. The program's goal is to provide those individuals with community supports or intensive intervention in a structured environment, when indicated, to resolve the emotional or behavioral issues threatening their community placement. A designated unit of eight ICF-MR certified beds provides diagnostic consultation; medical, behavioral, and psychiatric treatment; and as appropriate, short-term stabilization specifically for this population. When an inpatient admission is indicated, the maximum length of stay at the training center is targeted at 90 days, but it may be extended based on individual needs. Referrals must be made by a local Community Services Board (CSB), and oversight is provided by a regional council comprised of representatives from the CSBs, SWVTC, and Southwestern Virginia Mental Health Institute. Other training centers provide similar services, but not necessarily through a designated program or unit.

DBHDS *Comprehensive State Plans* since 2005 have noted an evolving role for the training centers in the continuum of care. The 2008-2014 plan was the first to report that all training centers are engaged in "...a cultural transition to person-centered processes and are expanding their mission to make short-term and transitional facility-based services more readily available." As noted earlier, DBHDS has implemented staff training on person-centered principles and practices at all of the training centers and CSBs, and further indicating progress, the 2010-2016 plan states that the training centers "...have expanded their missions to make short-term and transitional facility-based services more available." The future role for the training centers articulated by DBHDS is to be a support and temporary safety net to help individuals with intellectual disabilities remain in the community through provision of short-term respite care, crisis stabilization, assessment, and treatment for behavioral challenges and provision of services and supports for individuals with complex medical needs that cannot be met in the community until appropriate community services are made available.

Community ICFs-MR: Centers for Medicare and Medicaid Services (CMS) regulations require that public or private nonprofit or for-profit community ICFs-MR, like the state training centers, provide the core services listed above either directly or by contract and that their services be tailored to meet each individual's unique needs.

Nursing Facilities (Nursing Homes): Based on their residents' needs, nursing facility services may include assistance with and supervision of daily living, recreation, and social activities. Room and board, some medical equipment and supplies, and laundry services are included in the daily rate. Skilled nursing care as well as physical, occupational, and speech therapies and medical, dental, and pharmaceutical services are usually provided on premises. Additional equipment and other services, including adult day care or respite care, may also be provided.

E. Cost and Payment for Institutional Services

Services at all three types of institutions covered in this chapter are funded from both private and public sources. The national public health insurance programs, Medicare and Medicaid, are a significant source of funding. Other sources of payment include personal, out-of-pocket expenditures as well as various types of purchased private insurance such as long-term care insurance, Medicare Supplemental Insurance ("Medigap"), or managed care health insurance.

To receive reimbursement through Medicare or Medicaid, facilities must conform to specific federal **Centers for Medicare and Medicaid Services (CMS)** standards in eight operational areas: management, client rights, facility staffing, active treatment services, behavior and facility practices, health care services, physical environment, and dietetic services. To be "CMS certified" and thus eligible for reimbursement, a facility must be found to meet those standards based on an inspection by the designated state agency. Beds at a facility may be CMS certified for Medicare, Medicaid, or both under the following categories:

- **Skilled Nursing Facility (SNF):** Any long-term care bed specifically certified for Medicare reimbursement.

- Nursing Facility (NF): Any long-term bed specifically certified for Medicaid reimbursement.
- Intermediate Care Facility for Persons with Mental Retardation (ICF-MR): Any long-term care bed specifically certified for a Medicaid reimbursement program designated to provide care or supervision for residents who have a primary diagnosis of mental retardation (intellectual disability) or a developmental disability.

Intermediate Care Facility for Persons with Mental Retardation (ICF-MR): The table below compares the number of individuals served, total operational expenditures, and annual per capita cost for the state's training centers and community ICFs-MR for state fiscal years (SFY) 2005, 2007, and 2010. Detailed budget and expenditure information for the state's training centers were provided by the **Department of Behavioral Health and Developmental Services (DBHDS)**. Details of Medicaid expenditures related to Community ICFs-MR were provided by the **Department of Medical Assistance Services**. Information on persons and services covered by private payments is not available.

ICF-MR EXPENDITURES

Service Provider	Number Served	State Funds	Federal Funds	Other Funds	Total Funds	Per Capita Cost
SFY 2005						
State Training Centers*	1,524	\$27,641,581	\$169,331,755	\$164,161	\$197,137,497	\$129,355
Community ICFs-MR**	318	\$14,656,346	\$14,656,346	\$0	\$29,312,692	\$92,178
SFY 2007						
State Training Centers*	1,512	\$35,465,187	\$188,905,085	\$547,650	\$224,917,922	\$148,755
Community ICFs-MR**	340	\$19,833,047	\$19,833,047	\$0	\$39,666,094	\$116,664
SFY 2010						
State Training Centers*	1,197	\$107,779,606	\$125,956,724	\$366,091	\$234,102,421	\$195,574
Community ICFs-MR**	391	\$20,657,952	\$33,124,793	\$0	\$53,782,745	\$137,552

Sources: *Department of Behavioral Health and Developmental Services, Office of Developmental Services.

**Department of Medical Assistance Services (DMAS). Note that DMAS information for SFY 2005 has been updated since the 2008 edition of this assessment.

From SFY 2005 to SFY 2010, the number served by the state's training centers declined by 21.5 percent (327 individuals) while the number served at community ICFs-MR increased by 23 percent (73 individuals). Costs for both types of ICF-MR, however, grew considerably. Between SFY 2005 and SFY 2010, the annual per capita cost for the training centers increased by 51.2 percent (\$66,219), with the sharpest growth over the past three years during increased downsizing efforts by DBHDS. Per capita cost for community ICFs-MR grew at a similar rate over this period of 49.2 percent (\$45,374); nevertheless, their cost remains appreciably lower than for the training centers.

In addition to the operating expenditures detailed above, ICFs-MR have ongoing costs for maintenance and renovation, including modifications to meet federal life and safety and other plant standards. Funding for building maintenance and repair at the training centers comes from state general funds and state capital outlay funds that are appropriated by the General Assembly or obtained, with its approval, through the sale of bonds. As noted earlier, all of the training centers have buildings in use that are at least 35 years old, and two have even older buildings. According to the DBHDS 2008-2014 *Comprehensive State Plan*, inadequate funding over time for maintenance and renovation resulted in poor building conditions and aging structures that are often no longer appropriate for the needs of the individuals served and their programs.

The next table lists capital improvement expenditures for renovation and upgrading of residential areas and the physical plant at each of the state's training centers in state fiscal years (SFY) 2005 through 2010.

CAPITAL IMPROVEMENT EXPENDITURES AT VIRGINIA TRAINING CENTERS

Training Center	2006	2007	2008	2010
Central (CVTC)	\$1,417,683	\$4,341,256	\$2,500,000	\$1,985,554
Northern (NVTC)	\$379,936	\$1,153,474	\$1,000,000	\$0
Southeastern (SEVTC)	\$203,321	\$848,549	\$2,500,000	\$170,726
Southside (SVTC)	\$244,461	\$1,388,463	\$36,474	\$0
Southwestern (SWVTC)	\$978,188	\$2,555,031	\$0	\$1,727,456
Total	\$3,223,589	\$10,286,773	\$6,036,474	\$3,883,736

Source: Department of Behavioral Health and Developmental Services (DBHDS), Office of Fiscal Services.

The amounts shown above for Central Virginia Training Center (CVTC) and Southeastern Virginia Training Center (SEVTC) in SFY 2010 are the expenditures for that year from the General Assembly's 2009 appropriation of \$24.5 million for extensive renovations to CVTC and \$23 million for building of a replacement 75-bed facility for SEVTC. The remainder of those funds will be spent on these projects through SFY 2015. Including funds from that appropriation, the projected capital outlay budget for all state training centers in SFY 2011 is \$8,781,782.

In addition to funding for their residential services and capital outlays, the training centers receive funds to operate their outpatient **Regional Community Support Centers (RSCS)**. Funding for the RSCS at Northern Virginia Training Center to provide specialized medical services and clinical consultation, dental services, and respite care, as well as provider education and training, was first established in January 1996 as \$350,000 per year. Each of the four remaining training centers listed above has been appropriated \$200,000 per year from SFY 2009 through SFY 2012.

Nursing Facilities (Nursing Homes): Almost all nursing facilities in the state are certified for either Medicaid or Medicare according to the Virginia Department of Health (VDH), Division of

Long Term Care's website (www.vdh.virginia.gov/OLC/LongTermCare); however, public insurance coverages for these facilities vary. **Medicaid** will pay most costs incurred in a CMS-certified nursing facility for persons with income and assets meeting eligibility limits. Others, including about half of all nursing facility residents, pay costs out of their own savings, as noted in the CMS nursing home guide referenced earlier. Many individuals who move into nursing facilities initially do not qualify financially for Medicaid but eventually exhaust their savings and other resources, enabling them to become eligible for Medicaid. More detailed information on these eligibility requirements can be found in the Medicaid chapter of this assessment.

Most nursing facility care is not covered by the basic **Medicare** plan, but under limited conditions, it will pay for up to 90 days of certified skilled nursing facility care when an individual has had at least a three-day inpatient hospital stay immediately prior to the nursing home admission and the care has been determined to be medically necessary to recover from an illness or injury.

Medicare Supplemental Insurance, often called "**Medigap**," helps pay for items not covered by Medicare such as deductibles and copayments. Most Medigap plans will help pay for skilled nursing care, but only when that care is covered by Medicare. Some employer group health insurance plans and long-term care insurance plans can help cover nursing facility costs, but a managed care insurance plan will help pay for care only if it has a contract with a particular nursing facility. Cost and benefits for all of these types of plans vary widely, but many nursing facility residents who pay for care out of their own private funds receive some assistance from these plans. Video and written consumer information about them is available online through the National Association of Insurance Commissioners (NAIC), which represents state health insurance regulators (www.naic.org/cipr_topics_page.htm).

While much less expensive than intermediate care facilities for persons with mental retardation (ICFs-MR), annual nursing home costs are substantial. The *Genworth 2010 Cost of Care Survey* reports that the median annual cost of nursing home care in Virginia was \$65,700 for a semi-private room and \$73,000 for a private room. According to the Virginia Department of Medical Assistance Services (DMAS), a total of \$725.8 million in Medicaid funds were expended on nursing home care in state fiscal year (SFY) 2008, which represented 14 percent of all Medicaid expenditures for that year. In SFY 2010, the amount grew to \$793.4 million, 12 percent of all Medicaid expenditures.

In 2010, the Virginia General Assembly reduced Medicaid reimbursement rates for nursing homes by three percent effective in SFY 2012; however, the 2011 General Assembly voted to reverse that decision, eliminating the planned SFY 2010 rate reduction. The 2011 budget amendment also restored full funding to continue an incentive payment for long-stay rehabilitation hospitals in SFY 2012 that had been eliminated by the legislature in 2010. The amendment provided a total of \$50.6 million in general funds to cover both of these reauthorized expenditures.

F. Monitoring and Evaluation of Institutional Services

The Virginia Department of Health (VDH) and the Virginia Department of Behavioral Health and Developmental Services (DBHDS) have responsibilities for oversight and monitoring of all nursing facilities and public or private intermediate care facilities for persons with mental retardation (ICFs-MR). The jurisdictions and activities of each agency are different as further explained below.

Titles XVIII and XIX of the national *Social Security Act* (42 USC 1395 and 1396, respectively) require that each state designate an official “**survey and certification agency**” for Medicare and Medicaid that will monitor and certify facilities’ compliance with national standards of care on behalf of the federal **Centers for Medicare and Medicaid (CMS)**. The *Code of Virginia* (32.1-137) assigns this responsibility to **Virginia Department of Health (VDH)**, where it is carried out by the **Office of Licensure and Certification (OLC)**. VDH-OLC certifies the state’s training centers and public or private community ICFs-MR, and it licenses or certifies all nursing facilities statewide. Specific oversight duties for VDH-OLC specified by state statute include:

- Regulatory oversight of medical care service providers licensed by VDH through routine onsite investigations and by enforcing state licensure regulations;
- Receiving and investigating complaints by individuals regarding the quality of care for services provided by hospitals, nursing facilities, home care providers, hospice organizations, and the quality of care provided through managed care health insurance plans;
- Inspecting health care facilities, programs, and services for compliance with federal regulations, including Medicare, Medicaid, and clinical laboratory improvement programs; and
- Certifying the quality of care standards governing managed care health insurance plan providers and maintaining a registry of private review agencies.

VDH-OLC is required to conduct initial Medicare and Medicaid **certification surveys** for all new facilities and recertification surveys for each facility no later than 15 months after the last day of its previous survey. Unannounced onsite inspections to determine ongoing compliance with federal standards for health, safety, and quality of care are also required as part of the recertification process. Surveys are also required to investigate complaints, and “revisit” surveys determine if facilities have corrected previously cited deficiencies. Its surveyors are health care professionals such as physicians, registered nurses, dietitians, social workers, and laboratory medical technologists. To ensure uniform, consistent interpretation and application of federal standards, they receive extensive training in federal standards, survey techniques and procedures and methods for assessing direct services and treatment plans. Assessments of facility compliance with federal life and safety code requirements are provided by the Office of the Fire Marshall within the Virginia Department of Fire Programs under contract with VDH.

During each facility survey, VDH-OLC surveyors formally review clinical records as well as interview employees and individuals receiving services or their family members or guardians. Federal regulations require surveyors to directly observe the actual provision of services and care to individuals and, based on those systematic observations, assess the outcomes of care for individuals served as well as whether the services meet those individuals' current needs. Quality of care is further examined by reviewing facility data on outcome indicators for medical, nursing, and rehabilitative care; dietary and nutritional services; activities and social participation; sanitation and infection control; and physical plant conditions. The survey also includes a review of facility compliance with federal requirements for clients' rights.

If no deficiencies are found, surveyors deem the ICF-MR or nursing facility to be in compliance with standards. A finding of noncompliance results when deficiencies exist that have the potential to either result in more than a minimal impact on the individual served or compromise the individual's ability to "...maintain and/or reach his/her highest physical, mental and/or psychological well-being as defined by an accurate and comprehensive resident assessment, plan of care and provision of services." Noncompliant findings initiate a six-month enforcement period for correction. For both types of facilities, the most serious finding on noncompliance is immediate jeopardy, which means that noncompliance with standards either has caused or is likely to cause "serious injury, harm, impairment or death," and immediate corrective action is necessary. When this finding is made, the facility must immediately take all actions necessary to come into compliance with standards and to ensure processes that will prevent future reoccurrence, and these actions must be approved by the surveyors as being sufficient to resolve the citation.

Federal regulations establish several categories for citations of noncompliance with standards that apply to nursing and skilled nursing facilities, but not to ICFs-MR. Surveyors of these facilities must cite the seriousness of deficiencies based on their "severity," the degree of actual harm or potential for harm to individuals, and their "scope," whether they are isolated occurrences, constitute a pattern of care, or are widespread. "Substandard quality of care" (SQC) is a very serious citation of deficiency for nursing facilities that refers to either any deficiency in facility practices, resident quality of life, or quality of care that constitutes immediate jeopardy or a "pattern of widespread potential for or actual harm" that does not reach the level of immediate jeopardy (42 CFR 483.13 *et seq.*). As with immediate jeopardy, a nursing facility must immediately take corrective action.

After completing an inspection, VDH-OLC surveyors discuss their findings with the facility's administrator or designee. When a deficiency in meeting one or more standards is found, the facility administrator must submit a plan of correction that addresses each identified deficiency citation within a specified timeframe. VDH-OLC reviews the plan of correction and either accepts it or notifies the facility of any plan of correction item that it does not accept as adequately resolving a deficiency. When the latter occurs, the facility must revise the plan until accepted. The facility administrator is then responsible for ensuring that the plan of correction is

implemented and monitored so that compliance is maintained. A provider is expected to take the actions necessary to achieve compliance within 45 days of the findings notification.

VDH forwards each survey's findings to CMS and the **Virginia Department of Medical Assistance Services (DMAS)**, the state's designated Medicare and Medicaid administrative agency. Based on these findings, either CMS or DMAS may impose enforcement remedies for noncompliance with standards of care and, in the case of ICFs-MR, for noncompliance with their required "Conditions of Participation." Remedies may range from mandatory staff in-service training up to civil monetary penalties and denial of payment for new admissions. Termination of Medicaid or Medicare certification may be imposed on an ICF-MR that no longer meets the Conditions of Participation or when the facility's deficiencies pose immediate jeopardy to their residents' health and safety.

State and federal regulations authorize termination of the provider agreement for a nursing facility licensed by VDH if it still fails to comply with federal standards six months after a finding of noncompliance. Immediate imposition of administrative sanctions or civil penalties can also be imposed by the VDH Commissioner for noncompliant facilities when:

- The health and safety of residents are deemed at risk;
- Quality of care has been severely compromised;
- Illegal acts in the facility were permitted, aided or abetted; or
- The facility's program or services deviated significantly from those for which the license was issued without prior written approval from VDH-OLC or the facility failed to correct such deviation within a specified time.

Upon receipt of VDH's notice of intent to impose sanctions and its rationale for doing so, a facility licensed by VDH has the right to appeal under the state's *Administrative Process Act* (*Code of Virginia 2.24000 et seq.*). Possible sanctions that VDH may impose include:

- Restricting or prohibiting new admissions to the facility;
- Petitioning the court to impose a civil penalty (such as a fine), to appoint a receiver, or both; or
- Revoking or suspending the facility's license.

The **VDH-OLC Complaint Unit** has the responsibility for receiving and processing allegations of violations of the standards of care and of abuse, neglect, or exploitation of individuals served by nursing facilities and other providers that VDH licenses. Complaints may be made anonymously by phone (toll-free, 800-955-1819) or in writing using a Consumer Complaint Report form that is posted online along with a copy of the confidentiality policy (www.vdh.virginia.gov/OLC/Complaint/index.htm).

Complaints pertaining to the provision of health care that may seriously jeopardize patient health or safety or that relate directly to other state and federal regulatory requirements

are referred to a VDH-OLC surveyor for investigation, and when the investigation is complete, the licensee and the complainant, if known, are notified of its findings. When violations are found, the same procedures for resolution and monitoring described above for certification surveys applies. All investigative survey reports for nursing and skilled nursing facilities are also forwarded to the **State Office of the Long Term Care Ombudsman**, and that office is alerted of any findings of substandard quality of care (SQC). Additionally, whenever VDH-OLC finds that there has been abuse or neglect, it notifies the **Adult Protective Services Division** of the **Virginia Department of Social Services (DSS)**. If the facility is not found to be in violation of applicable state or federal regulations, the complainant, if known, is notified and informed other available options for addressing the complaint, including referral to the State Office of the Long Term Care Ombudsman or another appropriate state regulatory agency.

As Virginia's designated intellectual disabilities agency, the **Department of Behavioral Health and Developmental Services (DBHDS)** licenses community intermediate care facilities for persons with mental retardation (ICFs-MR) and has oversight responsibilities for the programmatic, financial, and administrative activities of the state's five training centers. It also licenses non-institutional providers of mental health, intellectual disability, and substance abuse services. The state's training centers are certified by VDH for Medicare and Medicaid but are not licensed by either agency. Like all ICFs-MR, however, they are subject to monitoring by the state **Office of the Inspector General (OIG) for Behavioral Health and Developmental Services** and the state and federally authorized **Virginia Office for Protection and Advocacy (VOPA)**. Additional information on oversight and monitoring responsibilities and activities of DBHDS and these other agencies related to non-institutional service providers can be found in the Community Supports chapter of this assessment.

The **DBHDS Office of Licensing** ensures that new community ICFs-MR comply with licensing regulations, policies, and procedures; that existing ICFs-MR maintain compliance; and that Child Protective Services reference checks, as well as criminal and central registry background checks, are conducted for all staff of all providers licensed by DBHDS. Office of Licensing staff process license renewals and written Service Modification Applications that must be submitted 30 to 60 days before a provider adds or changes either a service within a program or a program location. A New Applicant Training DVD covering these requirements is available from the office for a fee.

The *Code of Virginia* (37.2-400) further charges DBHDS with ensuring both the protection of human and civil rights and the provision of care consistent with human dignity for every person served by the training centers, community ICFs-MR, and all community programs that it operates, funds, or licenses, excluding those operated by the Department of Corrections. The **DBHDS Office of Human Rights** develops and monitors compliance with the human rights regulations (12 VAC 34-115-10) adopted and implemented by the State Board for Behavioral Health and Developmental Services in compliance with this state statute.

Issues addressed by these human rights regulations include, but are not limited to: protection from neglect, abuse, and exploitation; a nutritionally adequate diet; safe and sanitary

housing; participation in nontherapeutic labor; attendance or nonattendance at religious services; use of telephones; the availability of suitable clothing; and possession of money and valuables. Most importantly, they also address an individual's right to participate in decisions about his or her treatment and the due process procedures to be followed when an individual with a disability may not be able to make an informed decision.

Complaints about human rights violations are reviewed by **Local Human Rights Committees (LHRCs)** that serve specific regions of the state, and appeals are reviewed by the State Human Rights Committee. LHRCs also review and approve plans for human rights protections by license applicants and by institutions or programs renewing their licenses.

The State Board for Behavioral Health and Developmental Services also adopts and implements regulations requiring the public and private facilities and programs licensed or funded by DBHDS to supply the DBHDS Central Office with non-privileged information and statistical data related to:

- The results of investigations of abuse or neglect;
- Deaths and serious injuries;
- Instances of seclusion and restraint, including the duration, type, and rationale for use per person; and
- Findings by the DBHDS Office of Human Rights or by State or Local Human Rights Committees of any human rights violations or abuse or neglect of individuals with disabilities.

As noted above, the **Office of the Inspector General (OIG) for Behavioral Health and Developmental Services** provides additional oversight and monitoring for facilities or programs licensed or operated by DBHDS, primarily involving quality and standards of care issues. The *Code of Virginia* (37.2-424) authorizes the OIG to "...inspect, monitor and review the quality of services provided in state hospitals, Training Centers, licensed mental health treatment units in state correctional facilities, and in community programs...." Reports on each OIG onsite visit, study, or investigation are published on its website (www.oig.virginia.gov) and include its findings and recommendations for service or system improvements along with responses from the facilities or programs identifying the actions that they have taken or will be taking to address each OIG finding.

With respect to quality assurance for community ICFs-MR and the state's training centers, the OIG's duties include:

- Conducting announced and unannounced inspections on an ongoing basis and in response to specific complaints of abuse, neglect, or inadequate care or other information received and as a result of monitoring serious incident reports;
- Conducting unannounced inspections at each state facility at least once annually; and

- Making policy and operational recommendations to prevent problems, abuses, and deficiencies in programs and services and to improve the effectiveness of those programs and services.

The OIG conducted a systemic review of all five of the state's training centers in 2007 and, in May 2008, published a report (#139-07) that examined "...the extent to which the experiences of individuals in the Virginia training centers reflect the principles of self-determination, person-centered planning and choice." Inspection teams conducted unannounced visits lasting three to five days each at all training centers and included direct observations of a random sample of individuals at each facility both in the residential units and in on-campus day activities, interviews with staff, and record reviews. While the OIG's observations at all of the training centers found that staff interacted with clients in a respectful manner, some of its key findings were that:

- Training centers did not routinely offer opportunities for individuals to experience community integration through visits to local parks, shops, and other venues, and when offered, the majority of community outings occurred in groups of three or more individuals which limited personal integration and fostered segregation;
- The majority of training center clients did not have opportunities to participate in community-based events such as churches, service organizations, and recreational clubs;
- Individuals residing in the training centers were provided little opportunity for choice, and opportunities for new experiences to enable personal growth and enhanced choice were significantly limited; and
- Most individuals were not actively supported in achieving a valued role either in the facility or the community.

In 2008, the OIG also published a *Review of Active Findings for the State Operated Training Centers* (#150-08) to assess follow-up on findings of its 2005 systemic review of these facilities. During the intervening years, the DBHDS Office of Developmental Services led an initiative to promote person-centered principles in both community and facility services. The OIG review commended DBHDS and its Office of Developmental Services on their efforts to-date to clarify the current and future role of training centers within the service system and noted improvements in several areas that resolved previous OIG findings, such as:

- A completed review of strategic direction as well as organizational mission and values,
- Elimination of the use of isolated time-out at Southeastern Virginia Training Center (SEVTC),
- Developing plans to implement person-centered practices, and
- Regularly implemented evaluation processes with input from individuals served, families, and community providers on the quality of services and the effectiveness of the facilities' relationship with the broader service system.

Other past findings that remained active and subject to ongoing OIG and review included implementation of person-centered practices at each facility, increased programming space for vocational and life skills development at SEVTC and Southwestern Virginia Training Center (SWVTC), and increased efforts to provide opportunities for individuals served at the training centers to experience community integration.

The OIG conducted an inspection of the Pathways Program at SWVTC in 2009 that included client observations on the unit and record reviews. In its report (#176-09), the OIG complimented SWVTC on its documentation and person-centered practices, noting that:

- “Each of the 90-day records that were reviewed could serve as an exemplar for person-centered planning and comprehensive, integrated team effort” (page 6), and
- Behavioral plans were “... individualized, detailed, strength and preference-based, and consistently applied and documented” (page 7).

The OIG noted that several Pathways staff had worked in mental health, that all staff had training in co-occurring mental illness and behavioral management, and that resolution or improvement of behavioral issues was achieved in almost all cases. In addition the OIG found that Pathways provided extensive case consultations, including periodic psychiatric consultations, for individuals in the home community that diverted their admission to training centers. Pathways’ capacity to respond to emergencies, however, was found to be limited and the process to be “more complex and slower than desired.”

In its September 2010 *Semi-Annual Report*, the OIG noted that DBHDS was in the process of revising its training center admissions and discharge processes and, with respect to several related important and long-standing system issues, recommended that DBHDS complete work to:

- Establish a statewide policy on the role of training centers in providing emergency services for individuals who have co-occurring intellectual disability and mental illness or severe behavioral management challenges and formalize admission protocols accordingly;
- Develop and implement a formal plan to enable more consistent reporting of critical incidents across the training centers;
- Develop a standard method or process for determining “readiness for discharge” and implementing discharge to more integrated settings; and
- Increase efforts to “actively educate” family members or authorized representatives regarding community options.

This OIG report also provided the first summary of findings related to the **U.S. Department of Justice (DOJ)** investigation into potential violations of the *Civil Rights of Institutionalized Persons Act (CRIPA)* and Title II of the *Americans with Disabilities Act (ADA)* at Central Virginia Training Center (CVTC) near Lynchburg. DOJ notified the Commonwealth

of its intent to investigate in August 2008 and, as noted in the introduction to this chapter, issued its letter of findings in February 2011.

DHBDS hired consultants experienced in DOJ cases to provide technical assistance to the training center staff, and at the end of each site visit, DOJ consultants shared their initial findings and concerns about both CVTC and the state's service system for individuals with intellectual and other developmental disabilities with state counsel, CVTC administrators and staff, and other state officials. The OIG has been actively involved in monitoring these investigations as well as DBHDS activities to address DOJ findings. A very brief summary of the DOJ findings along with an online link to a more complete listing and the Governor's response was included in the introduction to this chapter.

The **Virginia Office for Protection and Advocacy (VOPA)**, as previously noted, serves as an additional oversight entity for the state's facilities and programs for individuals with disabilities. Authorization for its activities is provided by the various federal statutes and by the *Code of Virginia* (51.5-39.2) as:

“[T]he agency to protect and advocate for the rights of persons with mental, cognitive, sensory, physical or other disabilities and to receive federal funds on behalf of the Commonwealth of Virginia to implement the federal *Protection and Advocacy for Individuals with Mental Illness Act*, the federal *Developmental Disabilities Assistance and Bill of Rights Act*, the federal *Rehabilitation Act*, the *Virginians with Disabilities Act* and such other related programs as may be established by state and federal law.”

Prior to 2010, VOPA received approximately \$220,000 per year of state general funds to supplement the federal funding that primarily supported its activities. That year, however, the General Assembly eliminated its state funding, and at the time of this assessment, VOPA continues to operate without state support.

In carrying out its responsibilities to support and defend the rights of individuals with disabilities, the *Code of Virginia* (51.5-39.4) gives it the authority to:

- Resolve complaints concerning violations of individuals' rights when related to their disabilities and
- Access facilities, institutions, providers, and records of these facilities, institutions, and providers consistent with various sections of the *Code of Virginia*.

With regards to the latter, VOPA is specifically authorized to access records of an individual with a disability: “(1) who by reason of his mental or physical condition is unable to authorize the Office to have such access; (2) who does not have a legal guardian or for whom the Commonwealth, or designee of the Commonwealth, is the legal guardian; and (3) with respect to whom a complaint has been received by the Office or with respect to whom there is probable cause to believe that such person has been subjected to abuse or neglect.”

In conducting its investigations, VOPA may review records, interview clients, and observe care. When violations are found, it first attempts to resolve complaints through administrative remedies, but if violations are not resolved in a reasonable time, it has the authority to pursue legal or other alternative remedies to protect individuals' rights.

Directors of all state facilities operated by the Department of Behavioral Health and Developmental Services (DBHDS) are required by the Code of Virginia (37.2-709) to send information about critical incidents or deaths of clients to VOPA in writing within 48 hours of their occurrence. A critical incident is defined as being "...serious bodily injury or loss of consciousness requiring medical treatment." VOPA professionals review these reports to identify data trends as well as possible instances of abuse and neglect and conducts follow-up investigations as the office deems appropriate.

VOPA regularly monitors facility conditions and follows up on injuries to individuals served at the state's training centers and other institutions. Reports on most recently published investigation of an April 2009 incident at Southeastern Virginia Training Center (SEVTC) and its other investigations can be found online at www.vopa.state.va.us/Investigations/Investigations.htm. Its annual performance reports and other additional information on its activities and initiatives can be reached using links from that webpage.

G. Institutional Services Sources Referenced in This Chapter

Links to websites and online documents reflect their Internet addresses in March 2011. Some documents retrieved and utilized do not have a date of publication.

Websites:

Code of Federal Regulations (CFR):

www.gpoaccess.gov/cfr/index.html

Kaiser Family Foundation:

www.kff.org

Health Policy Explained:

www.kaiseredu.org

State Health Facts:

www.statehealthfacts.org

Office of the Inspector General for Behavioral Health and Developmental Services:

www.oig.virginia.gov

Office of the Secretary of Health and Human Services (HHR) of Virginia:

www.hhr.virginia.gov

Health Reform Initiative:

www.hhr.virginia.gov/Initiatives/HealthReform

National Association of Insurance Commissioners (NAIC):

www.naic.org

Consumer Guides:

www.naic.org/index_ltc_section.htm

National Long-Term Care Ombudsman Resource Center:

www.ltcombudsman.org

SeniorNavigator:

www.seniornavigator.org

U.S. Department of Health and Human Services (HHS):

www.hhs.gov

Centers for Medicare and Medicaid (CMS):

www.cms.gov

CMS Community Living Initiative:

www.cms.gov/CommunityServices/10_CommunityLivingInitiative.asp

Medicaid topics:

www.cms.gov/home/medicaid.asp

Medicare topics:

www.cms.gov/home/medicare.asp

My Medicare:

www.medicare.gov/default.aspx

Medicaid Nursing Home Compare:

www.medicare.gov/NHCompare/Home.asp

Nursing Homes, Paying for Care:

www.medicare.gov/nursing/Payment.asp

Office of Certification and Compliance:

www.cms.gov/CertificationandCompliance

Preadmission Screening and Resident Review (PASRR):

www.cms.gov/pasrr

National Clearinghouse for Long-Term Care Information:

www.longtermcare.gov/LTC/Main_Site/Planning_LTC/Information/index.aspx

U.S. *Social Security Act* (42 USC 1496):

www.ssa.gov/OP_Home/ssact/title19/1905.htm

Virginia Department for the Aging:

www.vda.virginia.gov

Office of the State Long-Term Care Ombudsman Program:

www.elderrightsva.org/default.aspx

Virginia Department of Behavioral Health and Developmental Services:

www.dbhds.virginia.gov

Virginia Department of Health:

www.vdh.virginia.gov

Division of Long-Term Care:

www.vdh.virginia.gov/OLC/LongTermCare

Laws, Regulations & Guidelines:
www.vdh.virginia.gov/OLC/Laws/index.htm

Office of Licensure & Certification:
www.vdh.virginia.gov/olc

Virginia Department of Medical Assistance:
www.dmas.virginia.gov

Money Follows the Person demonstration project:
www.olmsteadva.com/mfp

MDS 3.0 Section Q Implementation:
www.olmsteadva.com/mfp/MDS3SectionQ.htm

Virginia General Assembly:
<http://legis.state.va.us>

Code of Virginia:
<http://leg1.state.va.us>

House Appropriations Committee:
<http://hac.state.va.us/welcome.htm>

Senate Finance Committee:
<http://sfc.virginia.gov>

2011 State Budget:
<http://leg2.state.va.us/MoneyWeb.NSF/sb2011>

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VIII. Health

A. Introduction

The health services system for Virginians, with or without disabilities, is diverse and complex, involving sources of information, resources, and direct services at all levels of government and from nonprofit and for-profit organizations and practitioners. Describing all aspects of that system is beyond the scope of this assessment. The contents of this chapter will briefly detail the availability, provision, and financing of general and specialized preventative and recuperative care from public sources. Persons with disabilities may or may not be a recognized or readily identifiable recipient of these services which are more broadly targeted than some of the programs and services discussed in other assessment chapters. This chapter will also include certain programs directed at the general population that screen for disabilities and subsequently provide resources or referrals for related disability services. In some instances available services are covered more thoroughly in another assessment chapter and references will be made to those chapters so as not to duplicate information.

While all citizens require appropriate health care, individuals with disabilities often have additional complicating issues. Both physical and cognitive limitations can restrict their ability to exercise, eat healthy, and maintain an appropriate weight. Lifestyles are often sedentary due to mobility restrictions, and like many others without disabilities, persons with disabilities may lack an appreciation of the need and ways to exercise, or they may find that fitness equipment and programs have not been adapted to their needs or are inaccessible. Similarly, adapted examination and screening equipment is often unavailable or practitioners are poorly trained in its use. Wheelchair users and those dependent on therapeutic equipment may find it nearly impossible simply to determine and track their weight. Collectively, these factors and others contribute to greater risk for diabetes, heart and kidney disease, stroke, arthritis, certain types of cancer and infections, dental disease, and many other health problems related to lack of exercise, poor diet, obesity, and limited access to health and wellness services.

In March 2009, the Virginia Health Promotion for People with Disabilities (HPPD) project, administered by the Partnership for People with Disabilities (PPD) at Virginia Commonwealth University (VCU), released and disseminated *Health Status of Virginians with Disabilities 2004-2006*. This analysis of data from the Virginia Behavioral Risk Factor Surveillance System (BRFSS), scheduled to be updated in 2011, was prepared by the Division of Chronic Disease Prevention and Control at the Virginia Department of Health (VDH). While this report provides some relevant statistics regarding individuals with disabilities in the Commonwealth, it notes a number of limitations to its findings. Individuals who do not have access to a telephone to respond to the survey are potentially under-represented, its findings cover only adults, and those findings are based on self-reporting of disabilities and health status.

Notwithstanding these limitations, key findings from the analysis of information provided by the survey's 3,496 respondents included:

- Four in ten (38.5 percent) of adults with disabilities rated their health as fair or poor.
- People with disabilities are more apt to smoke, be overweight and obese, and twice as likely to not exercise as people without disabilities.
- They were less likely to have dental insurance and to suffer permanent loss of teeth due to decay or gum disease.
- They were nearly four times more likely to suffer falls with injuries, with rates similar for men and women and for older and younger adults.
- Individuals with disabilities were found to be three and a half times more likely to experience symptoms of depression.

The report, however, did have some positive findings. Individuals with disabilities were found to be more likely than the general public to have received influenza and pneumonia vaccines and to be less likely to drink alcohol or consume it in excessive quantities. Screening rates for major preventable cancers, with the exception of mammography, were similar to those for individuals with disabilities.

Federal health care reform, specifically the *Patient Protection and Affordable Care Act* passed by Congress on March 23, 2010, and the *Health Care and Education Reconciliation Act* passed on March 30, 2010 (collectively referred to by the former's name and acronym, **PPACA**), are at the center of current health care discussions and initiatives. A recent report to the Virginia Joint Commission on Health Care by its Senior Health Policy Analyst identified six major components of federal health care reform: (1) creation of new health insurance marketplace programs, (2) health insurance market reforms, (3) coverage of mandates and incentives, (4) changes to Medicare, (5) changes to Medicaid and the Children's Health Insurance Program (CHIP), and (6) improvements to quality of care and system performance.

A discussion of the details of federal health care reform and its implementation in Virginia is beyond the scope of this assessment. What it is important to note here is that implementation will be phased in over a number of years and that it will have significant impact on access to and delivery of health care services, including long-term care services for individuals with disabilities. The Association of University Centers on Disability (AUCD) has produced one of numerous summaries and analyses of PPACA (www.aucd.org/projects/health_reform/index.cfm). Although all of the bill's provisions are important to understand, some may be of particular interest to individuals with developmental disabilities. Specifically, AUCD reports that PPACA:

- "Establishes the CLASS Act program, a national, voluntary insurance program for purchasing community living assistance services and supports. Following a five-year vesting period, the program will provide individuals with functional limitations a cash

benefit of not less than an average of \$50 per day to purchase non-medical services and supports necessary to maintain community residence. The program is financed through voluntary payroll deductions: all working adults will be automatically enrolled in the program, unless they choose to opt-out. (Effective January 1, 2011)

- “Extends the Medicaid Money Follows the Person Rebalancing Demonstration program through September 2016 (effective 30 days following enactment) and allocates \$10 million per year for five years to continue the Aging and Disability Resource Center initiatives (funds appropriated for fiscal years 2010 through 2014).
- “Provides states with new options for offering home and community-based services through a Medicaid state plan rather than through a waiver for individuals with incomes up to 300% of the maximum SSI payment and who have a higher level of need and permits states to extend full Medicaid benefits to individuals receiving home and community-based services under a state plan. (Effective October 1, 2010)
- “Establishes the Community First Choice Option in Medicaid to provide community-based attendant supports and services for individuals with disabilities who require an institutional level of care. Provides states with an enhanced federal matching rate (FMAP) of an additional six (6) percentage points for reimbursable expenses in the program. (Effective October 1, 2011)
- “Creates the State Balancing Incentive Program to provide enhanced federal matching payments to eligible states to increase the proportion of non-institutionally-based long-term care services. Selected states will be eligible for FMAP increases for medical assistance expenditures for non-institutionally-based long-term services and supports. (Effective October 1, 2011 through September 30, 2015).”

Even as efforts are underway in the U.S. Congress to repeal federal health care reform and state challenges to the constitutionality of some PPACA provisions proceed through the courts, its implementation has begun. In August 2010, Governor McDonnell established the **Virginia Health Reform Initiative Advisory Council (VHRI)**. This 24 member panel, led by the Secretary of Health and Human Resources, was comprised of political, health system, civic, and business representatives and charged with developing innovative recommendations to implement health reform in Virginia. VHRI’s six task forces addressed system capacity, service delivery and payment reform, technology, insurance reform, purchaser perspectives, and Medicaid reform, which is discussed further in this assessment’s Medicaid chapter.

On December 20, 2010, the *Report of the Virginia Health Reform Initiative Advisory Council* (www.hhr.virginia.gov/Initiatives/HealthReform/) was presented to the Governor and released to the public. The report sets goals for the state to achieve within the next ten years, including being among the top ten states in terms of the health of its population, the overall quality of its health care system, and the quality of its patient experiences. It also calls for Virginia to retain well over half of the physicians it trains and for the state to be ranked among the bottom ten states in terms of both per capita costs and private insurance premiums. Challenges for the state, noted in the report, include that it is 41st in the nation in breast cancer

death rate and 35th in infant mortality. In addition, more than one million Virginians do not have health insurance and only 37 percent of small employers offer health insurance benefits to their employees, despite the fact that Virginia ranks sixth among the states in median family income. If and when implemented, the VHRI's comprehensive recommendations will affect all Virginians. Individuals with disabilities, their families, and advocates will need to pay close attention to the details of proposals resulting from its recommendations.

B. Eligibility for Health Services

As noted at its beginning, the multitude of health-related services available throughout the Commonwealth is beyond the scope of this chapter, and it will focus on those services administered, funded, or operated by the **Virginia Department of Health (VDH)**, as authorized by the *Code of Virginia* (32.1), and by other state agencies that are of particular relevance to individuals with disabilities and their families. Eligibility for these programs varies but, for the most part, applies equally to people with and without disabilities. Criteria typically relate to the individual's age, family income, and insurance coverage, as well as to whether the individual belongs to a group at special risk for a certain health problem now or in the future. The availability and nature of services across the state also varies based on local needs, funding, and differing risk levels for certain health problems. Data on the number of recipients of these services who have disabilities is generally not available.

Information in this section focuses on eligibility for direct services for individuals, where appropriate and available. Restrictions based on financial need are detailed later in the cost and payment section, and coverage of additional education and outreach programs of benefit to individuals with disabilities can be found in the access and delivery section. Relevant state and federal statutory information is also provided below as appropriate. Additional information can be obtained directly from VDH (www.vdh.virginia.gov/VDHprograms.htm) or local health departments.

The VDH **Baby Care** program is available to pregnant women with low incomes who are at risk of poor birth outcomes and need multiple services to ensure that they have healthy babies and become good mothers. The related **Resource Mother** program targets pregnant and parenting teens and their families from the time of pregnancy through the baby's first year.

Although it is a part of the Children and Youth with Special Health Care Needs (CYSHCN) program described further below, services from the **Virginia Bleeding Disorders Program (VBDP)** are available to persons of all ages who have congenital bleeding disorders. Outreach, direct services, and referrals are aimed at the general population, with particular emphasis on health care professionals, to facilitate identification of and care for Virginians with these inherited conditions. Any Virginia resident with hemophilia A, hemophilia B, or von Willebrand Disease may apply for the program, regardless of income; however, financial criteria must be met to receive services at no cost.

The **Breast and Cervical Care Early Detection Program (BCCEDP)**, known in the community as **Every Woman's Life**, targets uninsured or underinsured women with low income between the ages of 18 and 64.

The **Children and Youth with Special Health Care Needs (CYSHCN)** program administers multiple service networks that work with families, service providers, and local communities to identify children with serious, persistent health care needs and promote their optimal health and development. Its key programs are described briefly below.

- **Care Connection for Children (CCC)** targets children with medical disorders having a physical basis, including physical disabilities, that have lasted, or are expected to last, at least one year and that (1) require services above and beyond what is typical for a child's age or require special ongoing supports at home or school, (2) limit a child's abilities or activities in comparison with his or her peers, or (3) make the child dependent on compensatory medical or assistive services and supports. All children from birth to age 21 and their families are eligible for services.
- **Child Development Services (CDS)**, a parallel program to Care Connection, facilitates the availability and accessibility of services for children and adolescents suspected of or diagnosed as having learning, attention, emotional, or behavioral disorders, developmental disorders related to physical or sensory disabilities, developmental delay, intellectual disability, or a combination of problems. Referrals may be made by families, schools, physicians, local health or social services departments, and other community and professional agencies. Virginia residents from birth to age 21 are eligible for services. For fee-based services, a sliding scale based on income applies.
- The **Virginia Newborn Screening Program** and **Virginia Early Hearing Detection and Intervention Program (VEHDIP)**, within CYSHCN's **Genetics and Newborn Screening** unit, are responsible for ensuring that newborns are screened for potentially disabling conditions and are then directed to appropriate resources for follow-up. Both programs are aggressive in their outreach to the general population and especially to health care professionals and organizations.

The **VDH Dental Program** provides training and educational resources for dentists and other health care providers to increase their skills in caring for young children and others with special needs. While not specifically targeting individuals with special needs, clinical dental services are provided in approximately 21 health districts. Services are provided primarily for children and are based on income eligibility.

The **Virginia Healthy Start Initiative**, also known as **Loving Steps**, combines resources from a number of VDH programs to target localities in Virginia where the health of pregnant women, new mothers, infants, and toddlers is deemed to be at risk. Currently, Loving Steps services are provided in Westmoreland County and the cities of Norfolk and Petersburg.

VDH **HIV Care Services** administers funds to provide services and referrals for individuals with low incomes or disabilities who are not on Medicaid, have no other insurance or resources, and meet certain income limits. These funds are provided by the federal Health Resources and Services Administration as authorized by the *Ryan White Treatment Extension Act*. Individuals with cognitive and learning disabilities are at greater risk for contracting and spreading HIV/AIDS and have been identified by VDH as a population of special interest in its efforts to prevent spread of this disease.

All Virginians have access to screening, follow-up, and education services offered through the **Virginia Sickle Cell Awareness Program** for the detection and treatment of sickle cell disease. Children identified through the Virginia Newborn Screening Program, mentioned above, are eligible to receive services through Pediatric Comprehensive Sickle Cell Network. There are no financial eligibility requirements to receive services; however, each clinic offering services may charge fees for direct services based on income.

The **Virginia Vaccines for Children** program partners local practitioners with providers of vaccines to increase immunization levels for at-risk children. All vaccines required by law for school attendance may be obtained from local health departments, and vaccinations are available at no cost for individuals who are under the age of 19 and are either uninsured, underinsured, enrolled in Medicaid, or a Native American or Native Alaskan. Medicaid enrollment includes its managed care programs, and underinsured applies to lack of vaccination coverage.

The **Women, Infants and Children (WIC) Special Supplemental Nutrition Program** aims at improving the health of pregnant women, infants, and children under age five through better nutrition and access to health care. It is authorized and funded through the U.S. Department of Agriculture. WIC offices at local health departments screen potential participants for eligibility, and to be eligible, applicants must meet categorical, residential, income, and nutrition risk requirements.

The **Virginia Birth-Related Neurological Injury Compensation Program**, referred to simply as the birth-injury program, was created by the Virginia General Assembly in 1987 to address the malpractice insurance availability problems of obstetric services providers. The program pays for medical and certain other expenses for children who have severe neurological injuries received during birth. As a “no fault” alternative to obtaining compensation for these injuries through traditional malpractice litigation in the civil tort system, decisions regarding acceptance into the program are not based on a finding of malpractice. A family delivering a baby through the services of a participating physician or at a participating hospital must waive the right to bring a medical malpractice lawsuit against the participating physician or hospital in order to apply for and be accepted into the program. The *Code of Virginia* (38.2-5001) specifically defines eligibility requirements for infants who have received a neurological injury during a birth performed by a participating physician or at a participating hospital, and the Worker’s Compensation Commission conducts hearings and determines eligibility of claimants who seek entry into the program. The injury must have resulted from oxygen deprivation or mechanical injury during labor, delivery, or immediate post-delivery. The child must have a

permanent motor disability and developmental or cognitive disability and must need assistance with all activities of daily living.

C. Access to and Delivery of Health Services

Most direct health and wellness services are obtained from private nonprofit and for-profit organizations and practitioners which, as has been previously stated, are too numerous and diverse to cover in the framework of this assessment. With a few exceptions the public programs covered in this chapter primarily provide information on and referrals to these providers, support citizens in accessing them, or coordinate delivery of services between them. Access points for publicly provided health care assessment, management, and support services targeted specifically at people with disabilities are described below.

Programs Providing Direct Services:

As noted above, the **Virginia Department of Health (VDH)** is the primary agency focused on public health, and community-based sources of information and services are by far the most important element of the Commonwealth's public health service system for individuals with and without disabilities. A network of 35 local **health districts** supports 119 individual municipal health departments. Each of these has a unique combination of public and private resources, local health needs, and services. Unless otherwise indicated, the individual VDH health initiatives listed in this chapter operate through this network, either by directly providing services or by supporting local service providers. This network also collects data on health care needs and service levels, which is reported to VDH. Wherever specific access, enrollment, and participation information on a VDH service is available, it is included under the appropriate initiative.

VDH **Baby Care** programs can be accessed at 22 local health districts across the state, and **Resource Mothers** programs are available through 24 local health districts and other community agencies. Pregnant teens are referred to these programs by their peers, family members, local health departments, health practitioners and service providers, schools, and other community resources.

Referrals and service delivery for the **Virginia Bleeding Disorders Program (VBDP)** occur through four regional bleeding disorders centers with varying emphasis on pediatric and adult treatment. The co-occurrence of bleeding disorders and other disabilities and the overlap in outreach and professional networks result in reciprocal referrals between the bleeding disorders and broader disability services systems. Approximately 275 children and adults are served annually through this program.

Women can identify the closest screening sites for the VDH **Breast and Cervical Cancer Early Detection Program (BCCEDP)** program, also known as **Every Woman's Life**, by calling 866-395-4968 (toll-free) or e-mailing the program through its website,

www.vahealth.org/ew/. VDH reports that this network of 29 public and private nonprofit providers serves over 7,200 women annually.

Many public and private agencies provide care coordination services. These agencies assess individual and community needs, then develop the appropriate policies and practices required to provide or support a variety of services addressing those needs. The number served through VDH **Children and Youth with Special Health Care Needs (CYSHCN)** programs is a subset of the total number served, and its capacity is driven by financial resources and national standards for service delivery. To obtain a comprehensive view of the number of children receiving care coordination services would require data from all public and private agencies. In light of level funding for many years, it is positive that the number of children served by VDH has remained stable at about 3.5 percent of those potentially eligible for services.

The VDH 2010-2012 *Strategic Plan* reports that more than 208,400 children were potentially eligible for CYSHCN care coordination services in state fiscal year (SFY) 2010 and that 7,332 of them received those services. In SFY 2005, a total of 6,808 out of 190,600 potentially eligible children were served. The potential number of eligible children is based on U.S. Census data and estimated prevalence rates determined through the National Surveys of Children with Special Health Care Needs. U.S. Department of Health and Human Services' definitions used in this survey emphasize characteristics common to many of the conditions experienced by children with a wide range of diagnoses. The number served includes the children served by CYSHCN's Care Connection for Children, Child Development Services, and Virginia Blood Disorders Program described below.

- **Care Connection for Children (CCC)** coordinators, educational consultants, and insurance benefit specialists work from six regional Centers of Excellence for Children with Special Health Care Needs. Care Connection also performs community outreach and provides training and consultation to a wide variety of service providers that result in reciprocal referrals based on needs.
- **Child Development Services (CDS)** serves as a significant “gateway” and contributor to the disability services system. Each of nine regional Child Development Clinics managed by CDS has a team consisting of a pediatrician, nurse, social worker, educational consultant, psychologist, and other professionals as appropriate who assist families of children with learning, developmental, or behavioral disabilities. Referrals to the Child Development Clinics and regular or as-needed satellite or field clinics are made by families, schools, physicians, local health departments, social services offices, and other community and professional agencies.

VDH reports on the Virginia Performs website that CDS clinics served 1,235 children in state fiscal year (SFY) 2010. This is the lowest number since reporting began in 2004, when 1,730 children were served, and the trend has been downward since that time.

- The **CYSHCN Genetics and Newborn Screening** unit works through a multilayered network of public and private service providers, linked by particular health conditions or disabilities, to prevent birth defects and developmental disabilities, support optimal child development, and promote the health and wellness of children, adolescents, and their families. In accordance with Virginia law, these networks ensure that all newborns are screened for specific genetic disorders and for hearing loss. When these are detected, as also required by law, parents and service providers receive appropriate explanatory and follow-up information and referrals are made for appropriate medical or other services. The **Virginia Congenital Anomalies Reporting and Education System (VaCARES)**, another key component of the Genetics and Newborn Screening unit, is responsible for data surveillance related to these screening and follow-up activities.

The **Virginia Newborn Screening Program** works with three regional genetic centers operated by Virginia's medical schools to link families to appropriate resources in Virginia's disability services system. On Virginia Performs, VDH reports that 100 percent of Virginia newborns were screened for selected inherited disorders and genetic diseases and received follow-up by the age of six months in calendar year 2008, the latest year for which data is available. This reflected a slight increase from 99.8 percent who were screened in the previous year.

As a key partner with the Virginia Department for the Deaf and Hard of Hearing (DDHH), the **Virginia Early Hearing Detection and Intervention Program (VEHDIP)** serves as a primary source for referrals for follow-up services. VEHDIP staff are responsible for ensuring that physicians and hospitals provide all prospective parents with information on hearing screening requirements, that hearing screenings are performed, and that results of those screenings are provided to parents, physicians, other primary care providers, and VaCARES. The VDH website reports that 99.7 percent of newborns were screened for hearing loss prior to hospital discharge in calendar year 2008, the most recent data available, and the Virginia Performs website indicates that 56.4 percent of these infants received services before the age of six months. While this is a decline from a high of 70.5 percent in 2006, VDH staff believe that the actual number served may be higher because information on enrollment in IDEA Part C early intervention services (see the Early Intervention chapter for more information) cannot be shared without parental consent.

As noted earlier, the **VDH Dental Program** supports clinical dental services provided by 21 health districts across the Commonwealth. A searchable database of Virginia dentists who provide care for individuals with special needs can be found at www.vahealth.org/dental/.

Outreach, referrals, and funding under the *Ryan White Treatment Extension Act* are coordinated centrally by VDH **HIV Care Services** and regionally by "consortia" working in collaboration with local health departments and their community partners. VDH reports that 3,957 individuals received direct care and support services and 3,790 individuals received medications through this program in calendar year 2009. This reflects an increase from 2006

when 3,060 received direct care and 3,332 received medications. Women and children with HIV/AIDS must receive services in proportion to their burden of the disease, and for many individuals with and without disabilities, *Ryan White Treatment Extension Act* funding is their last resort for support of their health care and other needs.

All Virginia newborns are screened at birth for sickle cell disease through the Virginia Newborn Screening Program described above, and results are typically provided to the parents through their pediatrician. Local health departments also offer screening opportunities through the **Virginia Sickle Cell Awareness Program**, also described earlier. These and other referral sources direct families to Pediatric Comprehensive Sickle Cell Clinics, located in four major regional medical centers, for counseling, care coordination, and treatment. Additional community and professional educational and support services are offered through Community-Based Sickle Cell Programs.

The **Virginia Vaccines for Children** program conducts outreach and provides supplies of free vaccines to both public and private practitioners who then make them available to children with and without disabilities. The VDH central office, local health departments, and their community partners distribute information about the program, coordinate participating practitioners, and make referrals to them.

The VDH **Women, Infant, and Children (WIC) Program** ensures that eligible families, who might otherwise be unable to afford to eat properly, have access to healthy diets during pregnancy, breast-feeding, infancy, and early childhood to age five. Once eligibility has been determined, participants are directed to WIC staff and peer counselors who provide nutrition education, breast-feeding promotion and support, supplemental nutritious foods, counseling at WIC clinics, and screening and referrals for other health, welfare, and social services.

Families seeking to enter the **Virginia Birth-Related Neurological Injury Compensation Program** must file a petition with the Virginia Workers' Compensation Commission (WCC), and while it is not technically required, most families will need an attorney to represent them. Within 120 days of the petition filing, the case is reviewed a panel of expert physicians from one of the three state medical schools and by birth-injury program administrators, and there is an initial hearing by a WCC administrative judge. The WCC then enters a decision on eligibility and admission to the program, which either party can appeal to the full commission. Further appeals can be made to the Virginia Court of Appeals and the Supreme Court of Virginia.

The birth-injury program's *Comprehensive Annual Financial Report* covering the year that ended on December 31, 2009, the latest available, states that 11 petitions had been filed during that year and that 150 infants had been awarded benefits since the beginning of the program. Of those, five cases were still pending, and 113 program participants were still alive at that time. Minutes of the January 2011 meeting of the fund's board indicate that the number of active claimants rose to 117 by December 31, 2010, and minutes of the board's February 2011 meeting indicate a subsequent drop to 116.

Education, Information, and Outreach Programs:

Each of the eight **Area Health Education Centers (AHECs)**, coordinated by Virginia Commonwealth University, is a unique regional partnership of statewide and local educational resources, professional networks, public and private health care providers, VDH health districts, and municipal health departments. Their projects and resources are specific to the communities they serve and primarily target areas with shortages of health care providers and populations with greater numbers of Virginians at risk for poor health habits and chronic health conditions. Individual projects undertaken by AHECs vary, but generally, they seek to increase the number of health care providers in underserved areas, address educational, physical, and attitudinal barriers that restrict access to health and wellness services, and identify underserved members of the community and direct them to appropriate services. As a result, expanded and improved health care service for people with disabilities is frequently a goal and outcome of AHEC activities.

Child and family health services programs at the Virginia Department of Health (VDH) have collaborated to create **Bright Futures Virginia**, an information resource for families and health professionals. While Bright Futures does not specifically target families of children with disabilities or provide direct services, its “Guidelines” increase general awareness of what is developmentally appropriate and encourage routine, periodic screening for developmental delay. Its framework can then be used to assess the physical and mental health needs of children from birth through adolescence, determine if their progress is developmentally appropriate, and promote healthy growth and a smooth transition from pediatric to adult health services. The Bright Futures Virginia website (www.vahealth.org/brightfutures) provides information in video and printable formats that parents, caregivers, and health and human services professionals can access for up-to-date information on developmentally based well child care and anticipatory guidance. Launched in 2009, VDH reports that it now receives more than 20,000 visits per month. Infant growth, toilet training, discipline, and behavior are the top video topics accessed.

The VDH **Chronic Disease Self-Management Program (CDSMP)** trains leaders and master trainers to implement Stanford University’s evidence-based program that increases the knowledge and skills of patients living with chronic disease so that they can take responsibility for management of their disease, better manage day-to-day issues of the disease, improve their overall health, and decrease their utilization of health care resources. People with different chronic health problems attend CDSMP workshops together and meet with two trained leaders for two and a half hours, once a week, for six weeks, in community settings such as senior centers, churches, libraries, and hospitals. Requests to schedule programs in a community can be made by through the program’s website, www.vahealth.org/cdpc/CDSMP, or by contacting the VDH central office.

The mission of the **Health Promotion for People with Disabilities (HPPD)** project, as stated on its website (www.hppd.vcu.edu), is “to promote the health of people with disabilities, to prevent secondary conditions, and to eliminate disparities between people with and without disabilities in Virginia.” Initially established in 2002 as a part of VDH’s Division of Chronic

Disease Prevention and Control, it is now administered by the Partnership for People with Disabilities (PPD) at Virginia Commonwealth University. Funding for the project is provided by the National Center for Birth Defects and Developmental Disabilities at the Centers for Disease Control and Prevention (CDC). The project's task force works with local and national organizations in Virginia on awareness and education programs in health and recreation to implement its state plan goals related to access to health care, health promotion and outreach, nutrition and physical activity, data and surveillance, and interaction with existing initiatives.

The VDH **School Health Program** collaborates with the Virginia Department of Education (VDOE) in the supervision and coordination of school health services in the Commonwealth. State school health specialists develop and promote guidelines, educational materials, training programs, and other resources for all public school divisions as well as private and parochial schools. These guidelines and resources address health services for all students, with and without disabilities.

VDH's **Youth Suicide Prevention** program produces and distributes educational materials and conducts training for families, educators, and local service providers to raise public awareness and reduce the incidence of youth suicide. These materials include important referral information for Virginia's disability services system and are available free of charge from the program's website (www.vahealth.org/Injury/preventsuicideva/index.htm), the VDH central office, and the program's community partners.

Outreach, information, training, and direct services related to health care for the populations that they serve are also administered, provided, or licensed by a number of other state agencies, including the Department of Behavioral Health and Developmental Services (DBHDS) and the Departments for the Deaf and Hard of Hearing (DDHH), Blind and Vision Impaired (DBVI), and Aging (VDA). Rather than duplicate it here, additional information about these services can be found in the Community Supports and Institutional Services chapters of this assessment.

D. Available Health Services

Previous sections of this chapter describe Virginia's principal publicly funded health care information and service providers with specific relevance to people with disabilities. This section contains additional descriptions of direct services, beyond the provision of basic information and referrals. Further details can be obtained from websites and other references listed at the end of the chapter.

Services offered by individual providers in the Virginia Department of Health (VDH) **Baby Care** program vary but typically include care coordination, group childbirth education and smoking cessation programs, parenting classes, nutritional assessments and counseling, and homemaker services. Related services are available through VDH **Resource Mothers** who visit with pregnant and parenting teens and their families weekly to provide health education, model

daily living skills, make referrals to other resources including the disability services system and public insurance programs when appropriate, and guide teens in making a successful transition to parenthood.

Individuals participating in the **Virginia Bleeding Disorders Program (VBDP)** receive direct services from a regional team consisting of specially trained physicians, nurses, social workers, physical therapists, orthopedic surgeons, infectious disease specialists, dentists, genetic counselors, nutritionists, and educators. These teams develop and implement plans that address individuals' needs for services and supports, and they also assist families in coping with emotional, social, educational, financial, and workplace concerns.

The VDH **Breast and Cervical Cancer Early Detection Program (BCCEDP)**, also known as **Every Woman's Life**, begins with outreach to eligible populations, including women with disabilities and others who may experience barriers to care, and continues through follow-up to ensure that they receive recommended screenings and appropriate services. Services include clinical breast exams, mammograms, Pap tests, and Pelvic exams. Additional preventive and diagnostic screenings for cardiovascular disease and behavioral change programs covering nutrition, physical activity, and tobacco cessation are offered at participating sites through the **WISEWOMAN** program. The program also works with the **Health Promotion for People with Disabilities** project at Virginia Commonwealth University to arrange training for service providers to reduce barriers to preventive health screenings for women with disabilities.

Staff at the six regional **Care Connection for Children** Centers of Excellence for Children with Special Health Care Needs directly assist families of children diagnosed with medical disorders having a physical basis, including physical disabilities, obtain health care assessments and specialty medical care. This includes assisting them with determining and obtaining insurance coverage and payments from applicable private or public sources and gaining access to other relevant services and supports from the health and disability services systems. Care Connection staff also identify, train, and consult with potential additional community resources, particularly specialty medical services, to expand the available supply of providers and establish family-to-family support networks.

Teams at clinics operated by VDH **Child Development Services (CDS)** provide diagnostic assessments and develop plans for future services and supports for children with learning, developmental, or behavioral disabilities. They coordinate delivery of those services and supports with local departments of social services and health, Community Services Boards (CSBs) and mental health providers, school divisions, early intervention services, Head Start programs, and other resources as appropriate. CDS staff also seek out potential additional community resources, then provide them with guidance and training to expand the availability of services and supports. This active involvement in community outreach and training results in referrals to and from the program to other parts of the health and disability services system.

Direct services provided through the **Virginia Newborn Screening Program** are complex and vary considerably depending on the specific genetic condition. In general, newborn

screening staff ensure that physicians and hospitals collect necessary samples for testing by the Virginia Department of General Services' Division of Consolidated Laboratories under contract to VDH. They then ensure that parents, physicians, and primary care providers are notified of screening results and that parents are referred to the appropriate resources for follow-up. As noted earlier, test results and follow-up activities are also reported to the **Virginia Congenital Anomalies Reporting and Education System (VaCARES)**.

Further testing, counseling, education, and service referrals are provided by three regional genetic centers. In situations where metabolic treatments or special foods are required, families are referred to one of three regional metabolic treatment centers located at the same facilities. Physicians and nutritionists associated with those centers help to develop a plan of care, and in some instances consistent with financial and medical eligibility criteria, families can be provided with or reimbursed for necessary special formulas, foods, or supplements.

If screening identifies a child with current or potential hearing loss, the **Virginia Early Hearing Detection and Intervention Program (VEHDIP)** provides parents with information on the importance of early intervention, available resources, and what to expect in the future. Parents are directly assisted with arranging follow-up assessments and in obtaining communications and educational support, assistive technology, and other services, including referrals to appropriate resources of the Virginia Department for the Deaf and Hard of Hearing. VEHDIP staff develop policies and procedures, identify best practices, and recruit additional community resources. Their training and guidance ensure that physicians and hospitals provide all prospective parents with information on hearing screening requirements, that hearing screenings are performed, and that screening results are provided to VaCARES.

The **Virginia Healthy Start Initiative**, also known as **Loving Steps**, employs nurses, dietitians, and community health workers to provide case management services for women and infants who are at risk for poor perinatal outcomes. These case managers arrange screenings for medical, nutritional, social, economic, and environmental risks, identify service gaps, develop a plan of care, and make referrals to other services and resources to improve participants' health. Ongoing follow-up ensures that services and supports are being accessed. Outreach, health education, interconception care, and depression screening are also components of the program.

The VDH **Women, Infants and Children (WIC) Special Supplemental Nutrition Program** provides nutrition education, breast feeding promotion and support, supplemental nutritious foods, and counseling at WIC clinics. When appropriate, it refers clients for screenings and other health, welfare, social services, and disability services.

Services provided by the **Virginia Birth-Related Neurological Injury Compensation Program** are delineated in the *Code of Virginia* (38.2-5000 et seq.) and include medical, hospital, rehabilitation and therapy, residential and custodial care, compensation for lost earnings from ages 18 to 65, special equipment or facilities, reasonable claim filing costs including attorney's fees, and medically necessary travel. The program's current housing policy provides assistance for an accessible rental unit or a maximum of \$175,000 toward the cost of adding an

accessible bedroom and bath to a home. In addition, the program will fund the purchase of an accessible van when it becomes medically necessary for wheelchair transportation. Legislation passed in 2008 allows the program to reimburse for nursing or attendant care provided by a relative or legal guardian of a program participant. Expenditures that are not funded include those covered by other government programs such as Medicaid or Medicare, expenses covered by prepaid health plans or health maintenance organizations, and expenses covered by private insurance.

E. Cost and Payment for Health Services

In general, people with disabilities afford health and wellness services through the same means as the general population. Costs are paid directly out of pocket or indirectly through private insurance purchased individually or by employers or through public insurance programs such as Medicaid, Medicare, and the Children's Health Insurance Program (CHIP). They also take advantage of "free" government-funded services. This public funding is usually a mixture of federal, state, and local resources. The state's expenditures may be allocated from its General Funds or from dedicated sources. Numerous sources, including those mentioned at the start of this chapter, have reported that people with disabilities are typically poorer and have less access to private health insurance than the general population. This makes the population with disabilities and their families more reliant on public insurance programs and other government-subsidized services.

Concerns about the ever-rising costs of public insurance programs and limits to their coverage are resulting in annual changes to these programs as well as other acute and long-term health care programs of critical importance to persons with disabilities. At present, federal health care reform is driving changes to health care systems throughout the country, and like other states, Virginia continues to expand its use of managed care, including for individuals receiving long-term care. Provisions of the federal *Patient Protection and Affordable Care Act* (PPACA) will result in major changes to the health care delivery system. Changes to be phased in through 2014 will significantly expand the number of individuals eligible for Medicaid, and their full cost and programmatic impacts are not yet known.

Public health insurance programs that provide the most significant amounts of public health care funding for people with disabilities, such as Medicaid and CHIP, are addressed in the Medicaid chapter of this assessment. Other chapters also include information on numbers of participants and amounts of payments for health-related services as appropriate and available. The following funding sources are generally supplementary or complimentary to the publicly funded insurance programs. Each has its own application processes, eligibilities, and administrations unless otherwise noted. Unless otherwise indicated, funding amounts are for the entire programs and are not specific to services for individuals with disabilities.

The Virginia Department of Health (VDH) **Care Connection for Children** program manages a limited pool of funds that can be applied to certain services such as medications,

office visits to physicians and specialists, and durable medical equipment. Further information on services eligible for this pool of funds may be obtained from one of the six regional Centers of Excellence for Children with Special Health Care Needs. Before these funds can be used, it must be determined that no other resources such as private or public insurance are available. To qualify for these funds, a family must be uninsured or underinsured and have a gross family income at or below 300 percent of the federal poverty level. Financial support for Care Connection comes from Title V of the federal Maternal and Child Health (MCH) Block Grant program and matching Virginia General Funds.

VDH Child Development Services charges and payment procedures for services are discussed and determined in advance and will vary from family to family. A sliding scale based on family size and income level is available. The nine regional Child Development Clinics are also certified Medicaid providers for covered services. Child Development Services are financed by clinic fees and state General Funds that, as above, match federal support from Title V of the federal MCH Block Grant.

The **VDH Virginia Bleeding Disorders Program** manages a pool of funds that may be applied to certain services such as medications, diagnostic testing, therapy, and hospitalization. To qualify for these funds, a family must meet financial eligibility requirements that include not having any other resources such as public or private insurance. Again, these funds are derived from state General Funds that match federal support from Title V of the federal MCH Block Grant.

According to VDH, the **Virginia Newborn Screening Program** received \$974,657 in federal funds, plus \$952,807 in special funds, for a total of \$1,927,464 in state fiscal year (SFY) 2011. This included funding for medically necessary modified foods and supplements required by some individuals who have been diagnosed with heritable disorders or genetic diseases screened by the program and are receiving treatment at one its three regional genetic and metabolic treatment centers. Participating families with incomes of less than 300 percent of the federal poverty level and no insurance coverage for these special foods and supplements are eligible to be reimbursed for their cost up to a maximum of \$1,500 per individual per year. Individuals who do not qualify for reimbursement may purchase them through VDH at a discount.

VDH reports that in state fiscal year (SFY) 2011, total funding for the **Virginia Early Hearing Detection and Intervention Program (VEHDIP)** was \$425,000. Of this, \$150,000 came in the form of a federal grant from the Health Resources and Services Administration, and \$275,000 came from funds for Communicable Disease Control.

In state fiscal year (SFY) 2011, the state General Fund provided \$315,000 for the **Virginia Sickle Cell Awareness Program**'s network of pediatric comprehensive sickle cell clinics and \$90,000 for its community-based sickle cell programs. Reduced fees for services, based on a sliding scale, are charged to those who meet financial eligibility requirements.

Over the course of many years, the **Virginia Birth-Related Neurological Injury Compensation Program** has been the subject of substantial legislative and media focus. This attention has been directed primarily on the reported inability of severely injured children to obtain entry to the program, efforts to restrict access to the program, and concerns over its financial solvency. As noted previously, this fund covers medically necessary expenses beyond what private insurance, Medicare, or Medicaid will cover for approved participants in the fund who have suffered specific birth injuries during the labor and delivery process. No state funds are involved in providing services for claimants. Funding is derived from legislatively allowed sources that include fees charged to participating physicians and hospitals and assessments from nonparticipating physicians and liability insurers.

The 2008 General Assembly passed legislation to reduce the fund's actuarial deficit by increasing assessments for physicians and hospitals and requiring that the program employ the actuarial methodology used by the Florida Birth-Related Neurological Injury Compensation Association. The program's actuary noted that this increase in fees would have a minor effect on the deficit and that a more significant reduction would come from the change in actuarial methodology. The program's 2009 *Annual Actuarial Report*, the latest available, stated that the program was not in any immediate danger of defaulting on the payment of benefits and had sufficient assets to continue to pay for existing claimants' benefits for at least 20 years. Minutes from the January 2010 meeting of the fund's board noted that 2009 accomplishments included the highest level of physician participation (648), the highest level of hospital participation (38), the highest total annual income (\$30.36 million), and the highest participating physician and hospital income.

Minutes of the program's February 2011 board meeting reported that the fund had \$273 million in investments compared to \$235 million in January 2010 and \$186 million in January 2009. Those minutes also included a statement from the fund's board, pursuant to a letter from Pinnacle Actuarial Resources, Inc., that "the Program has enough money in reserves to cover the current costs of all admitted claimants. However, the Program is still considered actuarially unsound."

The 2011 General Assembly passed House Bill 2170 which amended the *Code of Virginia* (38.2-5009) to prohibit the Workers' Compensation Commission from awarding attorney fees incurred in opposing a claimant's admission to the birth-injury program. The measure also prohibited the award of attorney's fees and expenses incurred by any physician, hospital, nurse midwife, or their medical malpractice carrier that is a party to a proceeding regarding admission to the program or involving a birth-related neurological injury claim. This prohibition on paying expenses does not apply to compensation of the Office of the Attorney General or certain other expenses.

F. Monitoring and Evaluation of Health Services

It is not possible to address the entire system for monitoring and evaluating the performance and responsiveness of the health care system in this assessment. While people with

disabilities may be an identified or likely component of the target populations for the health services described in this chapter, most of these services are not specific to people with disabilities, and therefore, the service providers do not collect or report separate quality assurance information for that population. What follows is a general description of quality assurance mechanisms related to the services described previously. More information, including detailed monitoring and complaint procedures and compliance reports, where available, may be found using the references at the end of this chapter.

Virginia Department of Health (VDH): Examples of monitoring, regulatory, and quality assurance responsibilities for individual VDH programs have already been covered in the earlier sections of this chapter on eligibility for and access to health care. In addition, the VDH **Office of Licensure and Certification** is responsible for licensing, monitoring, and managing compliance for a wide range of public and private health care facilities and service providers such as hospitals, outpatient clinics, certain laboratories and other testing facilities, nursing facilities, home care organizations, and hospice programs. Information on its quality assurance activities relative to direct services for people with disabilities may be found in the Community Supports and Institutional Services chapters of this assessment.

The VDH Office of Licensure and Certification is also responsible for certification of managed care health insurance plans under Titles XVIII and XIX of the federal *Social Security Act* (42 USC 1395 and 1396 et seq., respectively). This office is also the state's official survey agency for providers eligible for reimbursements under Medicaid and Medicare. Specific certification, inspection, monitoring, and compliance requirements vary by type of service, and details can be found on the office's website (www.vdh.virginia.gov/OLC/index.htm) along with procedures for submitting and resolving service complaints.

Virginia Department of Health Professions (DHP): Thirteen DHP regulatory boards oversee and enforce laws governing approximately 350,000 health care workers in Virginia. These boards develop regulations and make case decision regarding whether a provider is in violation with requirements for obtaining or retaining a license. The department grants licenses, certifications, and registrations; handles concerns and complaints about service providers; and collects workforce data. As a public service, it also has an online system for checking the current licensure status of health professionals, practitioners' records in the Board of Medicine's database, and the results of recent case decisions on complaints. Lists of covered professions, information on professional standards, complaint procedures, and forms are available on its website (www.dhp.virginia.gov) or by contacting VDH directly.

Virginia Department of Medical Assistance Services (DMAS): Activities by DMAS to monitor expenditures and provide quality assurance for the state's public health insurance programs are described in the Medicaid chapter of this assessment.

Virginia Birth-Related Neurological Injury Compensation Program: While it was created by the Virginia General Assembly, the birth-injury program is an independent organization governed by a board appointed by the Governor. Initially comprised of seven members, board

membership was expanded to nine on July 1, 2008. The *Code of Virginia* specifically defines how the program is to operate, and the State Corporation Commission (SCC) has certain financial responsibilities regarding the fund that supports its operation. The program's plan of operation is approved by the SCC, and at least every other year, the SCC is required to conduct an actuarial study of the program.

An independent financial audit must be performed annually and submitted to the Governor and both chambers of the Virginia General Assembly along with an annual investment performance report. Its *Comprehensive Annual Financial Reports* and annual actuarial reports, the most recently published for 2009, are available at www.vabirthinjury.com. In 2007-2008, the birth-injury program received awards for Excellence in Financial reporting; however, in May 2009, its former claims manager was sentenced to ten years in prison for embezzling nearly \$800,000 from the fund.

G. Health Services Sources Referenced in This Chapter

Links to websites and online documents reflect their Internet addresses in March 2011. Some documents retrieved and utilized do not have a date of publication.

Websites:

Area Health Education Centers:

www.ahec.vcu.edu

Association of University Centers on Developmental Disabilities:

www.aucd.org

Health Promotion for People with Disabilities:

www.hppd.vcu.edu

Kaiser Family Foundation State Health Facts:

www.statehealthfacts.org

Virginia Birth-Related Neurological Injury Compensation Program:

www.vabirthinjury.com

Board meeting minutes and actuarial reports:

www.vabirthinjury.com/News_Publications.htm

Virginia Department of Health:

www.vdh.virginia.gov

Baby Care:

www.vahealth.org/babycare

Behavioral Risk Factor Surveillance System:

www.vahealth.org/Brfss

Bleeding Disorders Program:

www.vahealth.org/bleedingdisorders/index.htm

Breast and Cervical Care Early Detection Program (Every Woman's Life):

www.vahealth.org/ewl

- Bright Futures Virginia:
www.vahealth.org/brightfutures
- Care Connection for Children:
www.vahealth.org/specialchildren/ccprogram.asp
- Child Development Services:
www.vahealth.org/specialchildren/cdsprogram.asp
- Children With Special Health Care Needs:
www.vahealth.org/specialchildren
- Congenital Anomalies Reporting and Education System (VaCARES):
www.vahealth.org/gns/vaCares.htm
- Dental Health:
www.vahealth.org/dental
- Early Hearing Detection and Intervention:
www.vahealth.org/hearing
- Genetics and Newborn Screening:
www.vahealth.org/gns
- Healthy Start Initiative (Loving Steps):
www.vahealth.org/lovingsteps
- HIV Care Services:
www.vdh.virginia.gov/epidemiology/DiseasePrevention/HCS
- Infant Screening and Infant Tracking System:
www.vahealth.org/gns/visits/visits.htm
- Licensure and Certification:
www.vdh.virginia.gov/OLC/index.htm
- Newborn Screening:
www.vahealth.org/vnsp
- Regional Genetic Centers:
www.vahealth.org/gns/centers.htm
- Resource Mothers:
www.vahealth.org/resourcemothers
- School Health:
www.vahealth.org/chiladolescenthealth/schoolhealth
- Sickle Cell Awareness:
www.vahealth.org/sicklecell
- Virginia Vaccines for Children:
www.vdh.virginia.gov/Epidemiology/Immunization/VFC/index.htm
- Women, Infants and Children (WIC) Special Supplemental Nutrition:
www.vahealth.org/NuPAFP/General%20Info
- Youth Suicide Prevention:
www.vahealth.org/Injury/preventsuicideva/index.htm
- Virginia Department of Health Professions:
www.dhp.virginia.gov

Documents:

- Association of University Centers on Developmental Disabilities (AUCD). (May 2010). *AUCD Summary of the Patient Protection and Affordable Care Act: A Detailed Summary of Provisions that Impact AUCD Network Programs*. Retrieved from: www.aucd.org/docs/policy/health_care/Section%20by%20Section%20summary%20of%20LTSS%20in%20HCR%20law%205-5-10.pdf.
- Oliver Wyman Actuarial Consulting, Inc. (October 2009). *Virginia Birth-Related Neurological Injury Compensation Fund: 2009 Annual Report Including Projections for Program Years 2009-2011*. Report to the State Corporation Commission, Bureau of Insurance. Retrieved from: www.vabirthinjury.com/News_Publications.htm.
- Virginia Birth-Related Neurological Injury Compensation Program. (January 2010). *Board of Director's Meeting: Minutes: January 12, 2010*. Retrieved from: www.vabirthinjury.com/News_Publications.htm.
- Virginia Birth-Related Neurological Injury Compensation Program. (July 2010). *Board of Director's Meeting: Minutes: July 13, 2010*. Retrieved from: www.vabirthinjury.com/News_Publications.htm.
- Virginia Birth-Related Neurological Injury Compensation Program. (January 2011). *Board of Director's Meeting: Minutes: January 18, 2011*. Retrieved from: www.vabirthinjury.com/News_Publications.htm.
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- Virginia Department of Health, Division of Chronic Disease Prevention and Control. *Chronic Disease in Virginia: A Comprehensive Data Report, 2006 Edition*. Richmond. Retrieved from: www.vahealth.org/cdpc/documents/2007/2006%20Chronic%20Disease%20Data%20Report_040607.pdf.
- Virginia Department of Health, Division of Chronic Disease Prevention and Control. (March 2009). *Health Status of Virginians with Disabilities: 2004-2006--An Analysis of BRFSS Data*. Disseminated by Health Promotions for People with Disabilities Project, Partnership for People with Disabilities, Virginia Commonwealth University. Retrieved from: www.hppd.vcu.edu/documents/HPPD_Disability_Report_2009-Color.pdf.

IX. Community Housing

A. Introduction

Living in and being a member of one's community requires housing. Suitable, safe, affordable, and accessible housing is the foundation of inclusive communities with opportunities for education, employment, relationships, and active participation. In Virginia and nationally, citizens are being priced out of the housing market, especially individuals with disabilities receiving Supplemental Security Income (SSI) benefits or whose income is otherwise limited. Many people with disabilities can and would choose to live independently with or without supports if they had access to affordable, accessible housing options. This chapter emphasizes the availability and sources of affordable accessible housing for people with disabilities, particularly those with low to moderate incomes.

To create real and meaningful opportunities to reverse Virginia's historic institutional bias in funding of housing for people with disabilities, it is necessary to acknowledge the community housing challenges associated with the deep poverty that a majority of people with disabilities experience. Median income is an important housing policy indicator because most government housing programs have eligibility requirements related to median income. Under current federal guidelines, housing is considered to be affordable for low-income households when the cost of monthly rent, including tenant-paid utilities, does not exceed 30 percent of monthly household income. Data reported in *Priced Out in 2008: The Housing Crisis for People with Disabilities* and *Out of Reach 2008* by the National Low Income Housing Coalition show that the annual income of a single individual in Virginia receiving SSI equaled only 15.6 percent of median income. This is almost 30 percent below the 2008 federal poverty level of \$10,400 for an individual, and as a result, the housing affordability gap for people with disabilities in the Commonwealth is significant.

Key factors contributing to this gap between supply and demand for affordable, accessible housing in Virginia have been identified, and despite current efforts by state and local agencies and other providers, limited resources and aging of the general population are expected to widen this gap. According to the *2009 American Community Survey Estimates* (www.uscensus2010data.com/51-virginia-household-education-immigration-demographics), Virginia's population that year included 831,775 non-institutionalized individuals with a disability. Of those, 65,085 were under age 18; 440,575 were between ages 18 and 65; and 326,115 were over age 65. The Social Security Disability Insurance Program's 2009 annual statistical summary (www.ssa.gov/policy/docs/statcomps/di_asr/2009/sect01.html#chart2) reports that 207,482 of Virginians between ages 18 and 65 received SSI, Social Security Disability Income (SSDI), or both, and 218,064 total individuals of all ages received SSI or both. For individuals, regardless of age, who rely on SSI benefits as their major or only source of income, the cost of housing makes it virtually impossible to afford decent, safe housing in their

local community. Virginians receiving SSI benefits are at extreme levels of poverty and facing a housing crisis.

In the ten years since it was first published, *Priced Out in 2008* reports that the amount of monthly SSI income, adjusted for inflation, that is needed to rent a modest one-bedroom unit has risen an astonishing 62 percent, from \$462 (69 percent of SSI) in 1998 to \$749 (112 percent of SSI) in 2008. Other data in this report supports the statement above that individuals with disabilities who rely on SSI payments as their source of income continue to be some of the poorest people in the nation. Together, these two national reports provide a vivid picture of the housing challenges faced by Virginians, with and without disabilities, who have low to moderate incomes.

- In 2008, to afford the Average Fair Market Rent of \$941 per month for a two-bedroom unit without paying more than 30 percent of income on housing, a household had to earn \$3,136 monthly (\$37,635 annually). Working 40 hours per week, 52 weeks per year, this equates to an hourly wage of \$18.09, which is referred to as the “Housing Wage.”
- That same year, a worker earning the minimum wage of \$5.85 per hour could afford monthly rent of no more than \$268 and would need to work more than 127 hours per week to afford a two-bedroom unit at the state’s Average Fair Market Rent.
- Based on federal guidelines, a SSI recipient receiving \$637 per month, the unreduced benefit amount for 2008, could afford monthly rent of no more than \$191 at 30 percent of that monthly SSI benefit, well below the Average Fair Market Rent of \$818 for a one-bedroom unit. That year, in Virginia, 82,629 non-elderly adults (ages 18 to 64) with disabilities received SSI benefits.

Nationwide, since the release of these reports, SSI benefit increases have not kept up with rising housing costs. The unreduced SSI benefit as of January 1, 2011, is \$674 for an individual and \$1,011 for a couple. The annual cost of operating one unit of affordable housing funded by the Virginia Housing Development Authority (VHDA) can range from \$3,000 to \$5,000 per unit, before factoring in debt service or mortgage payments. As noted above, people with disabilities receiving SSI can only afford to pay 30 percent of their income in housing costs, which as of January 1, 2011 is \$202 per month or \$2,424 per year.

Virginia now ranks among the ten lowest states in average income for a person with a disability receiving SSI, and the situation is more severe in rapidly growing urban areas than in the state as a whole. Affordability is at the core of providing accessible community housing for individuals with disabilities and a wide range of options, including such things as ongoing rent subsidies, must be considered. With this in mind, a discussion of other related issues and steps being taken to address them in Virginia follows.

Since the 1999 U.S. Supreme Court decision in *Olmstead v. L.C.* (www.law.cornell.edu/supct/html/98-536.ZS.html) requiring that individuals with disabilities be served in the most integrated setting appropriate to their needs, the development of affordable, accessible

community housing for people with disabilities has been identified as a needed priority nationwide. In Virginia and across the country, the federal **Money Follows the Person (MFP)** demonstration and other initiatives aimed at moving individuals from institutions to the community have been hampered by the lack of affordable, accessible housing.

The income barriers identified above and a lack of comprehensive coordination of resources on the federal, state, and local level have perpetuated a long-standing disconnect between housing and disability services agencies. In Virginia, momentum has been building during the past two years to bridge this disconnect. The state's *Comprehensive Cross-Governmental Strategic Plan to Assure Continued Community Integration of Virginians with Disabilities* was developed and adopted in 2007 in response to the *Olmstead* decision, following development of numerous recommendations by a multi-year Olmstead Task Force. As of March 2011, the latest update of this strategic plan, released in June 2009, was under review and revision. It contains the following housing expectations:

- “Housing will be accessible for people leaving institutions or at risk of becoming institutionalized.
- “Housing will be affordable for people leaving institutions or at risk of becoming institutionalized.
- “Housing will be available and appropriately located.”

Virginia's **Community Integration Advisory Commission** and the associated **Community Integration Implementation Team** have been involved in a wide variety of interagency activities in support of these goals. Two federally funded initiatives administered by the Department of Medical Assistance Services (DMAS), the MFP demonstration mentioned above and the **Systems Transformation Grant** discussed further in the Community Supports chapter of this assessment, are also underway to bring system reform to services spanning multiple agencies.

In late February 2011, the **U.S. Department of Justice (DOJ)** issued finding from its investigation of Central Virginia Training Center, which was expanded to all five of the state's training centers. In that report, discussed in greater detail in the Institutional Services chapter, DOJ found that the Commonwealth was not in compliance with the *Olmstead* decision or the mandate under the *Americans with Disabilities Act* to provide services for individuals with disabilities in the most integrated setting. Ensuring sufficient affordable, accessible community housing options is sure to be a component of the negotiations now going on between the state and DOJ. The DOJ report will likely also shape activities by the Community Integration Advisory Commission and Implementation Team.

The *2008-2010 Statewide Plan for Independent Living*, developed by the **Virginia Statewide Independent Living Council (SILC)**, features additional goals and activities to improve housing planning, coordination, and options. The SILC, created under the *Code of Virginia* (51.5-25.1), is an independent planning body that promotes community inclusion,

participation, and access for all Virginians with disabilities. Recognizing the need for disability advocates to participate more effectively in housing policy discussions and to influence the allocation and use of federal housing resources, the SILC strategic plan sets specific goals and calls for activities, including the commitment of financial resources, addressing housing needs. To carry out the SILC's plan, local **Centers for Independent Living (CILs)** will:

- “Work with the Office of Community Integration and the Money Follows the Person (MFP) Housing Task Force to determine local housing capacity needs and develop and pursue strategies to address those local housing needs with appropriate local, state and federal policymakers.
- “Support development of the Money Follows the Person Operational Protocol to identify means of informing residents of institutional settings of community living options and assist them in becoming better self-advocates when they make the transition into the community.
- “Improve housing policy on the local and state levels by ensuring that the housing needs of people with disabilities moving from institutions to the community are included in local plans and planning processes.
- “Enhance the knowledge of HUD [the U.S. Department of Housing and Urban Development] and local housing authorities on the housing/community living needs and preferences of people with disabilities.
- “Create a mechanism to track local changes in public policy and relate ongoing needs/solutions to statewide and national housing funding agents and authorities.”

CILs have been successful in facilitating dialogs and opportunities at the local and state level that better integrate housing for people with disabilities into planning processes. Local government involvement in statewide planning efforts is critical if housing capacity for Virginians with disabilities is to be increased. The *Comprehensive Cross-Governmental Strategic Plan* acknowledges this critical link, and the SILC goals demonstrate a coordinated effort to work toward positive solutions and outcomes.

CILs have also been successful in developing relationships locally and statewide with staff of **public housing agencies (PHAs)** and other housing officials, educating them on the housing needs and preferences of people with disabilities. The impressive response of PHAs in Virginia to HUD's Notice of Funding Availability (NOFA) for “Housing Choice” Vouchers for non-elderly people with disabilities (Category I) and additional (Category II) vouchers to enable non-elderly households with disabilities to transition from nursing homes and other health care institutions into the community was a direct result of the CILs' advocacy and their collaboration with the Virginia Housing Development Authority (VHDA) and the MFP demonstration project. On October 1, 2010, HUD announced Category I voucher awards, and Virginia received 463 vouchers, the nation's third largest state total. Unfortunately, Virginia did not receive an allocation of Category II vouchers.

In 2009, the Virginia General Assembly (2009 *Appropriations Act*, Item 315.Z) directed the Department of Behavioral Health and Developmental Services (DBHDS), in conjunction with VHDA, the Department of Housing and Community Development (DHCD), the Virginia Association of Community Services Boards (VACSB), the Arc of Virginia, and the Virginia Network of Private Providers (VNPP), to conduct a study and “report on investment models and best practices for the development of affordable and accessible community-based housing for persons with intellectual and related developmental disabilities.” While not a mandated partner in this study, the Virginia Board for People with Disabilities (VBPD) was invited to join the study group and was an active participant in its work. The study’s recommendations (www.dbhds.virginia.gov/documents/reports/omr-HousingReport-2009.pdf), which have helped guide DBHDS efforts to develop partnerships and create community living opportunities, recognize the need to:

1. Develop a state policy and plan to expand critically needed community housing options for people with intellectual and related developmental disabilities. Current efforts to develop community-based housing for individuals with intellectual and related developmental disabilities are fragmented. Housing options must be affordable, accessible and reflect Virginia’s “person-centered” vision for serving people with disabilities.
2. Prioritize, target, and align state agency investments of assistance with that strategic plan. State strategic investment priorities will help to organize and align federal, state, local, and private investment resources which can significantly increase the development of integrated community housing for individuals with intellectual and related developmental disabilities. The state agencies that should participate in the development of the investment priorities are: DBHDS, DHCD, VHDA, and DMAS. The leadership of state agencies is critical in supporting the development of local coalitions aimed at increasing affordable and accessible housing options. Further, Virginia’s disability services agencies must become fluent regarding Virginia’s federal housing resources and the prioritization of those resources.
3. Invest in the development of innovative housing and financing models that can effectively leverage affordable housing finance capital and private investor resources. Three related steps to this recommendation are:
 - Build the capacity and willingness of the housing development community to provide desired community housing options;
 - Establish program priorities for the federal housing resources allocated to Virginia, including any National Housing Trust Fund resources, which are aligned with state investment priorities for addressing the community housing needs of people with intellectual and related developmental disabilities; and
 - Direct the Virginia Housing Commission to study General Obligation bond use for housing in Virginia, including any Virginia specific legal concerns.

4. Establish a community living supplement program for room and board to support the choice of community housing. A supplement of this kind will help solidify Virginians' commitment to individuals who reject institutional living.
5. Convene a meeting of agency heads from DBHDS, VHDA, and DHCD to consider the adoption of and updated Memorandum of Understanding (MOU).
6. Establish a permanent state source for education and training to provide a resource for Community Services Boards (CSBs) and others to continually connect housing and the needs of people with intellectual and related developmental disabilities.
7. Direct the Disability Commission, through the state interagency Housing Expansion Task Force and in conjunction with the Housing Commission, to conduct an annual review of Virginia's implementation of these recommendations in future years.

As values shift toward community inclusion and full citizenship for people with disabilities, the focus on needed community housing grows. Individuals with disabilities desire control over decisions about where, how, and with whom they will live. They want decent, safe, affordable, and accessible housing as well as access to the services and supports that they need to live as independently as possible. Best practice models of housing choice and community integration for people with disabilities do not couple the two within a particular residential setting.

Conversations taking place today, in Virginia and nationally, emphasize the decoupling of housing and services in favor of a “**supportive housing**” model. The goal of this movement is to help people with disabilities control their own lives, become socially and economically productive, and have the opportunity to live in permanent, independent, affordable, and accessible housing. There are various iterations of the supportive housing model. All emphasize consumer choice and control over both housing and services in contrast to the “placement” approach in which professional assessments constitute the main basis for housing selection. The supportive housing approach leads to separation of housing from services, an emphasis on conventional, integrated, scattered-site housing to reduce stigma, and rights of tenancy under landlord/tenant laws.

On April 10, 2010, Governor Bob McDonnell issued *Executive Order No. 10* calling for a *Housing Policy Framework for the Commonwealth of Virginia* “to establish broad goals and policy direction related to housing policy and to coordinate a comprehensive and effective housing policy with other public policy areas and initiatives across multiple secretariats within the executive branch.” The executive order identified four guiding principles necessary for the housing policy framework:

1. Recognize the role of the housing industry as a critical economic development engine within the Commonwealth by streamlining regulations, ensuring robust finance and construction sectors, promoting the development of workforce housing, reducing commute times between home and work, and increasing residential access to transportation systems, while furthering public understanding of housing finance and economic literacy.

2. Promote sustainable and vibrant communities through measures that promote mixed use development, increase energy efficiency and use of cost-effective green building concepts, support the rehabilitation of substandard housing, clarify the role of community associations in common interest communities, and expand public-private cooperation in addressing affordable safe housing.
3. Ensure that a range of housing options can be provided to meet the housing needs of a dynamic and changing population, achieve proper balance between homeownership and rental options, promote a continuum of quality housing options for special needs populations, match existing subsidies with areas of housing need, and increase the emphasis on fair housing (eliminating barriers to housing).
4. Increase capacity to address the needs of homeless Virginians by focusing on the reduction of chronic homelessness, ensuring the continued viability of the safety net of shelters and services, and investing in transitional and permanent supportive housing.

Executive Order No. 10 was the first executive branch effort to craft a comprehensive, state-level housing policy framework for Virginia. The Governor's Senior Economic Advisor, the Secretary of Commerce and Trade, the Director of the Department of Housing and Community Development, the Executive Director of the Virginia Housing Development Authority, and others were responsible for carrying out its provisions. A Housing Policy Initiative Work Group and Advisory Committee representing diverse groups of stakeholders and constituents was established. The work group started by building on efforts several years ago by the Virginia Housing Commission. Results of this initiative included:

- Creation of the Virginia Foreclosure Task Force to provide timely response to emerging issues related to foreclosure and housing market recovery;
- An initial action plan to increase state capacity to address the needs of homeless Virginians; and
- Fourteen policy recommendations addressing the need to streamline regulations, better link housing with jobs and transportation, promote sustainable communities, and ensure the provision of a range of housing options for all Virginians.

Policy recommendations in the interim report (www.virginiahousingpolicy.com) solidify continued commitment to cross-secretariat coordination. Specific recommendations of note are the need for: (1) better linkage of housing, transportation, and land use planning and use of the **Transportation and Housing Alliance Toolkit** (www.tjpd.org/housing/thatookit.asp) by localities as a best practice, (2) the need to maintain and enhance administrative structures that support interagency and inter-secretariat collaboration in addressing special housing needs, (3) a continuum of quality housing options for special needs populations consistent with the U.S. Supreme Court's 1999 *Olmstead* decision, and (4) establishment and promotion of state policy priorities for the incorporation of "visitability" and "**universal design**" elements in private housing development. On the latter the report further recommends that "once voluntary standards are adopted, charge state agencies with identifying specific means for promoting their

use through development of voluntary program incentives, provision of technical assistance, and public-private partnerships.”

Universal design refers to items or home features that are usable by most people regardless of their level of ability or disability. Many accessible and adaptive features are universally usable. For example, round doorknobs are not usable by people with limited use of their hands, but lever handles are usable by almost everyone, including people who have no hands. Universal design addresses the scope of accessibility and promotes making all elements and spaces accessible to and usable by all people to the greatest extent possible.

There are currently no national or state universal design standards that interface consistently with accessibility amenities in housing. The **Center for Universal Design** (www.ncsu.edu/www/ncsu/design/sod5/cud/index.htm) is a national information, technical assistance, and research center that evaluates, develops, and promotes accessible and universal design in housing, commercial, and public facilities, outdoor environments, and products. The center’s mission is to improve environments and products through design innovation, research, education, and design assistance.

Two additional key initiatives have influenced the availability of accessible housing. During its 2011 session, the Virginia General Assembly voted to increase the **Livable Home Tax Credit** from \$2,000 to \$5,000 for new homes and retrofitting of current homes that meet specific visitability and universal design requirements. Additional information on this tax credit program appears in the cost and payment section of this chapter.

Complementing the tax credit, the Virginia **EasyLiving Home** certification program (www.elhomes.org), established through the work of a coalition of public and private organizations, encourages the inclusion of key features that make a home cost effective, accessible, and convenient for everyone. This voluntary certification specifies criteria in everyday construction that builders can incorporate into new homes to make them welcoming to residents and their friends, family, and visitors, regardless of age, size, or physical ability.

Multiple governmental and private nonprofit and for-profit entities, including but not limited to the Virginia Housing Development Authority (VHDA) and the state Department of Housing and Community Development (DHCD) are involved in funding, developing, and providing community housing and related services. Together, DHCD and VHDA provide the “bricks and mortar” of access to affordable housing in Virginia. They administer a range of federal grant funding and tax incentives for housing and community development projects and programs. Brief introductions to several key initiatives and agencies appear below.

The Virginia **Department of Housing and Community Development (DHCD)**, www.dhcd.virginia.gov) works in partnership with local governments, state and federal agencies, nonprofit groups, and others to make Virginia’s communities safe, affordable, and prosperous places in which to live, work, and do business. Each year, DHCD invests more than \$100 million in housing and community development projects throughout Virginia. The majority of

these projects are designed to help persons with low to moderate incomes and are explained in greater detail later in this chapter. In addition, DHCD works to ensure safe buildings and homes by administering Virginia's building and fire codes as well as by training and certifying the state's building officials. It also administers the Livable Home Tax Credit mentioned above.

The **Virginia Housing Development Authority (VHDA)**, www.vhda.com) is the state's mortgage finance agency. Created in 1972 by the Virginia General Assembly, the VHDA's mission is to "help low- and moderate-income Virginians attain quality, affordable housing." As an independent public authority, VHDA receives no state appropriations for its operations and is fully self-supporting from revenues generated by its programs. VHDA has a Disabilities Housing Solutions Group, comprised of representatives of housing organizations actively engaged in developing affordable, accessible housing, that seeks workable, cost-effective means for using available public resources to better serve the needs of people with disabilities.

Several VHDA administered programs have particular significance for people with disabilities. **Low-Income Housing Tax Credits** support the development of affordable rental housing. VHDA also administers the **Housing Choice Vouchers** mentioned earlier on behalf of localities that either lack the capacity or do not wish to administer them directly. VHDA further provides mortgage financing for developers of affordable, accessible, and safe-housing options as well as offers flexible mortgage financing for the purchase of homes by individuals with low and moderate incomes. These programs increase the inventory of accessible, affordable housing and expand opportunities and choices for persons with disabilities to live independently. In some instances, people with disabilities who are able to find housing through a Housing Choice Voucher, but need and are eligible for other services and supports to live in the community, can work with their service provider to develop the "wrap-around services" they need to stay in the community.

Additional options for persons with disabilities to live in the community are provided through group homes and sponsored residential placements licensed by the **Department of Behavioral Health and Developmental Services (DBHDS)**, assisted living facilities (ALFs) licensed by the **Department of Social Services (DSS)**, and adult foster care, an optional service provided in coordination with local departments of social services. These are described more fully later in this chapter. Nursing facilities and other institutional settings are covered in the Institutional Services chapter of this report.

B. Eligibility for Community Housing Services and Programs

Department of Housing and Community Development (DHCD): The majority of projects funded by DHCD are designed to help persons with low to moderate incomes through an array of housing and community development projects and programs. Individual programs address preservation of housing stock as well as housing for targeted groups such as the homeless and persons diagnosed with HIV/AIDS, first-time home buyers, and others. Eligibility requirements are complex and vary among projects and programs, making it impossible to cover them

adequately within the limited framework of this assessment. Detailed information can be obtained at www.dhcd.virginia.gov or by contacting the department directly.

Virginia Housing Development Authority (VHDA): Educational programs and financial services offered by VHDA target individual home buyers or renters as well as developers and builders of a wide range of housing options. As with DHCD above, programs addressing the needs of individuals with low to moderate incomes, such as the Housing Choice Voucher and home loans, have income and affordability restrictions. Programs for developers and builders may require the building of a certain number of affordable housing units for funded projects. Complete information on current eligibility requirements for each of these problems can best be obtained at www.vhda.com or by contacting the authority directly.

Department of Social Services (DSS): Although persons with intellectual disabilities or other developmental disabilities may reside in **assisted living facilities (ALFs)** licensed by DSS, persons with mental illness are typically their primary residents. Local departments of social services determine eligibility for admittance using the **Uniform Assessment Instrument (UAI)**, www.cdaaa.org/images/UAI.pdf). The UAI gathers information to assess an individual's care needs and eligibility for planning and monitoring care across multiple agencies and services. In addition to its use by local departments of social services, it has been used by local departments of health, Area Agencies on Aging (AAAs), the Department of Rehabilitative Services (DRS), Medicaid funded long-term care service providers, and Medicaid nursing facility preadmission screening teams since July 1994.

Adult foster care (AFC) is a community-based contractual arrangement, authorized by the *Code of Virginia* (63.2-1601 and 63.2-800), involving DSS, a local department of social services, an approved service provider, and an individual intending to utilize AFC services. No more than three individuals may receive AFC services at one time in the home of an approved provider, regardless of whether those services are funded privately or through an Auxiliary Grant described below. To provide care for more than three individuals requires licensure by DSS as an assisted living facility.

DSS Auxiliary Grants are a source of additional income for recipients of Supplemental Security Income (SSI) benefits or for those who would qualify for SSI benefits according to the criteria below except for "having income in excess of set limits." Recipients must reside in an assisted living facility (ALF) licensed by DSS or in an adult foster care home approved by local departments of social services. Not all ALFs, however, accept Auxiliary Grant recipients.

Eligibility for Auxiliary Grant benefits is determined by the department of social services in the Virginia city or county where the individual last lived outside of an institution or an adult foster care home. Any records or statements can be used to determine residency. If residency cannot be determined or if the individual is from out-of-state, residency is based on where the individual is living at the time of application. To be eligible, an individual must:

- ✓ Be blind, have a disability, or be age 65 or older;

- ✓ Reside in a licensed assisted living facility or approved adult foster care home;
- ✓ Be a citizen of the United States or an alien who meets specified criteria;
- ✓ Have a countable income less than the total of the Auxiliary Grant rate approved for the ALF plus the personal needs allowance;
- ✓ Have non exempted resources less than \$2,000 for one person or \$3,000 for a couple; and
- ✓ Have been assessed and determined to need assisted living facility care or adult foster care placement.

According to the DSS *Fiscal Year 2010 Adult Services Program Report*, which summarizes data from the Adult Services and Adult Protective Services (ASAPS) case management system, Auxiliary Grants were received by 5,078 residents of assisted living facilities and 26 residents of adult foster care in state fiscal year (SFY) 2010. Of these, 1,966 were classified as “aged,” 28 were blind, and 3,110 had a disability.

Department of Behavioral Health and Developmental Services (DBHDS): As described in earlier chapters of this assessment, local **Community Services Boards (CSBs)** are the single point of entry in Virginia for all publicly funded services for persons with intellectual disabilities, including **residential services** such as placement in a DBHDS licensed group home. While there are some individuals who reside in group homes whose services are funded through state General Fund dollars that flow through CSBs, the Medicaid Home and Community Based Services Intellectual Disability (ID) Waiver is the primary source of funding for residential placement of people with intellectual disabilities in DBHDS licensed group homes.

Eligibility for residential supports requires that a person have a diagnosis of intellectual disability. The CSB then determines and documents that the person’s functional needs can be met by, and are appropriate for, group home placement and that the individual chooses to receive services through the ID Waiver rather than receive institutional services. The appropriate level of residential supports is based on each person’s needs and his or her natural supports, and under the ID Waiver, residential supports and services may also be delivered to an individual in his or her home, if appropriate, rather than in a group home.

It is important to note that similar support for congregate residential services is not available through the Individual and Family Developmental Disability (DD) Waiver; however, the DD Waiver does provide support for individuals residing in their own home or apartment and does allow for shared residences that are not considered congregate. More information on Home and Community Based Waivers can be found in the Medicaid chapter of this assessment.

C. Access to and Delivery of Community Housing Services and Programs

Department of Housing and Community Development (DHCD): Funding and services provided by DHCD are channeled through state and local governmental agencies, nonprofits, and other intermediaries who provide direct services for consumers. DHCD is not a direct service

provider to individuals with disabilities. For access to DHCD funding, organizations respond to Requests for Proposals or submit grant applications in accordance with program requirements and established deadlines. Depending on the funding opportunity, awards are made either competitively or on a first-come, first-served basis. Eligibility and application details for funding opportunities may be obtained from the DHCD website or by contacting the agency directly.

Virginia Housing and Development Authority (VHDA): Recipients of VHDA educational and financial services include individuals and families, state and local agencies, nonprofit organizations, and commercial builders and developers. Initial inquiries can be made through the VHDA website or by contacting VHDA directly. Beyond that, access and delivery procedures vary widely between programs and are too complex and numerous to detail in this assessment.

Housing Choice Vouchers, funded by the U.S. Department of Housing and Urban Development (HUD), are available through a network of 41 public housing agencies (PHAs) acting directly on behalf of HUD and 34 additional local agencies overseen by VHDA. A complete listing of these agencies, which administer the vouchers and determine eligibility for them taking into account family size and annual gross income, is available on the VHDA website.

Voucher funding is limited and insufficient to provide rental assistance for all who request them. As a result, housing agencies maintain waiting lists of eligible applicants. As of November 15, 2010, VHDA reported 6,600 applicants on waiting lists for agencies that it oversees, and that all 34 of those agencies had closed their waiting lists to new applicants.

When a voucher becomes available and is issued to an individual or family, the voucher holder must find a rental unit and a willing landlord. The unit must be inspected by the agency administering the voucher, and the rent requested must be reasonable for the market area. The housing assistance payment authorized by the voucher is paid by VHDA directly to the landlord, and the voucher holder pays the difference between the actual rent charged by the landlord and the amount subsidized by the voucher.

In April 2010, HUD published a Notice of Funding Availability (NOFA) for approximately \$40 million for approximately 5,300 Housing Choice Vouchers for nonelderly people with disabilities. This national NOFA represented one of the first collaborations between HUD and the U.S. Department of Health and Human Services as a part of President Obama's "Year of Community Living" and included two categories of vouchers. Category I vouchers may be used by nonelderly individuals with disabilities and their families to access affordable housing in a community that adequately meets their needs. Up to 1,000 Category II vouchers specifically target nonelderly individuals with disabilities currently living in nursing homes and other health care institutions to allow them to move into the community.

As mentioned in this chapter's introduction, Centers for Independent Living (CILs) worked closely with PHAs, encouraging them to apply for the vouchers. In October 2010, HUD awarded 463 Category I vouchers to six Virginia PHAs, as detailed below.

HUD CATEGORY I HOUSING CHOICE VOUCHER AWARDS, OCTOBER 2010

Public Housing Agency	Funding	Vouchers
Harrisonburg Redevelopment and Housing Authority	\$557,820	100
Newport News Redevelopment and Housing Authority	\$371,022	50
Norfolk Redevelopment and Housing Authority	\$1,192,986	150
Portsmouth Redevelopment and Housing Authority	\$819,903	93
Prince William County, Office of Housing and Community Development	\$840,882	70
TOTAL	\$3,782,613	463

The federal *Quality Housing and Work Responsibilities Act* of 1998 (QHWRA) established a requirement that public housing agencies maintain a comprehensive planning document known as a **Public Housing Agency (PHA) Plan**. The *Priced Out in 2006* report cited earlier notes that, in addition to new requirements for the PHAs such as the creation of these plans, this statute "gave PHAs more flexibility and control over how federal public housing and Section 8 Housing Choice Voucher programs are used in their communities."

A PHA Plan, produced in consultation with a Resident Advisory Board, outlines the policies, programs, and strategies that the public housing agency will implement in order to meet local housing needs. As their names suggest, the two parts of this plan, the Five-Year Plan and the Annual Plan, are updated every fifth year and every year, respectively. The PHA Plan describes the agency's overall mission for serving families with low and very low incomes and the activities that will be undertaken to meet their needs. It should also be consistent with the local jurisdiction's **Consolidated Plan** (ConPlan). Both plans include a statement of the housing needs of families with low and very low incomes and describe how the PHA's resources, specifically federal public housing funds and the Housing Choice Voucher program, will be used to meet those needs. For example, through its PHA Plan, local housing officials could decide to direct more Housing Choice Vouchers to people with disabilities receiving Supplemental Security Income (SSI) benefits.

In 2004, with support from the Virginia Board for People with Disabilities, the Virginia Housing Development Authority (VHDA) created **Access Virginia** (www.accessva.org), a website with a comprehensive collection of information for locating accessible apartments and learning more about accessibility requirements and universal design principles. This website was a positive step forward in helping Virginians investigate and obtain affordable, accessible housing; however, to reach its potential and maximize its benefits, it is critical that its contents be kept current. To meet this need, VHDA partnered with Socialserv.com, a nonprofit organization dedicated to helping people access affordable housing and supportive services by developing solutions that utilize leading edge technology. The original Access Virginia search engine was

replaced with a link from its website to VirginiaHousingSearch.com. Socialserv.com's staff ensures that listings at this site are up-to-date and accurate, conducts housing searches for tenants, and helps owners/landlords input listings and update property information.

Department of Social Services (DSS): Following determination of eligibility and level of care needed by their local department of social services, an individual with a disability typically works with his or her case manager to select a DSS licensed **assisted living facility (ALF)**. Then, at admission, the individual receives a service agreement and a preliminary service plan based on results determined through the **Uniform Assessment Instrument (UAI)** and other relevant information. The admissions director or another appropriate employee of the ALF reviews the UAI with the individual and explains how the facility can meet his or her needs through the service plan. Standards allow up to 45 days for completion of a final service plan so that the facility can obtain a more accurate picture of the needs and capabilities of the resident. This is helpful for individuals who may be in some degree of crisis at entry or need time to adjust to the new residence.

There were 549 licensed ALFs with a licensed bed capacity of 31,275 in Virginia as of June 2010 according to the *Fiscal Year 2010 Adult Services Program Report*. These counts, however, are fluid and can change monthly. Just over 300 of the licensed ALFs accepted individuals with **Auxiliary Grants**. Some may accept only one or two residents with an Auxiliary Grant, while in other facilities nearly all of the residents may receive one.

There has been a consistent decline in Auxiliary Grant caseloads at local departments of social services for the past ten years. In 2009, three-quarters of the 78 local departments of social services with declines in their caseloads during state fiscal years (SFYs) 2007 and 2008 responded to a survey that identified the three top reasons for this decline: ALF providers are unable to accept Auxiliary Grant recipients because the grant rate is insufficient for them to provide for recipients' required needs, the needs of Auxiliary Grant recipients exceed ALF levels of care, or individuals choose to remain at home and utilize home-based services, Medicaid Home and Community Based Services (HCBS) Waivers, or case management by Community Services Boards (CSBs).

In addition, due to current DSS licensure requirements and Medicaid HCBS Waiver regulations, very few people with intellectual or developmental disabilities are being served in assisted living settings. Those facilities face the same challenges as group homes in providing small quality residential settings and will likewise require higher provider rates or supplemental funding assistance to become a viable community housing alternative for that population.

Virginia state agencies, auxiliary grant recipients, and advocates have expressed a desire to pursue portability of the Auxiliary Grant and additional funding structures that could efficiently and effectively support an array of quality supportive housing alternatives. Progress has been stymied by concerns related to Maintenance of Effort (MOE) requirements ensuring that federal cost of living adjustments are passed along to individuals receiving Supplemental Security Income (SSI) benefits. Efforts to test the feasibilities of alternatives to current SSI and MOE pass-along provisions, which would enhance and be complementary to community integration and Money Follows the Person initiatives, are worthy of continued exploration.

Adult foster care (AFC) is an optional service. Local departments of social services are responsible for approving AFC homes in which their placements are made, and they can only approve AFC homes in which they intend to make placements. Individuals who have their own resources may reside in an approved AFC home if they meet the same assessment criteria as an individual receiving an Auxiliary Grant and if the local department of social services board has approved privately paid services at an AFC in that locality. Services by approved AFC providers are bound by standards in the DSS Adult Services Manual (22 VAC 40-771). Currently, 28 local departments of social services have been authorized by their boards to offer AFC services, and there are 58 AFC providers in Virginia serving 67 adults.

Sponsored residential homes, described below, and AFC homes provide a similar housing choice, however, while AFC is an approved setting for services under the Medicaid HCBS Intellectual Disability (ID) Waiver, restrictions in some local social services jurisdictions have made it difficult to serve ID Waiver recipients in AFC homes. In addition, licensing regulations by the Department of Behavioral Health and Developmental Services (DBHDS) prohibit sponsored residential home providers from being dually approved as AFC providers.

Department of Behavioral Health and Developmental Services (DBHDS): After an individual has been determined to be eligible for the Medicaid Home and Community Based Services (HCBS) Intellectual Disability (ID) Waiver and has selected community rather than institutional **residential services** option, his or her Community Services Board (CSB) case manager submits the required enrollment information to the DBHDS Office of Developmental Services (ODS). If no ID Waiver “slot” is available to the CSB, the individual’s name is placed on a waiting list until a slot becomes available. The CSB case manager is responsible for notifying the individual or family of placement on the ID Waiver Waiting List in writing within ten days of notification by ODS and must also provide notification of appeal rights and processes. Once an individual receives an ID Waiver slot, the individual can choose a residential services provider. Detailed information on ID Waiver Waiting List policies and procedures are found in the Community Supports chapter of this assessment.

DBHDS tracks the “static capacity” for ID residential services by level of service. Static capacity refers to the number of beds for which a facility is licensed and staffed or the number for which it is contracted during the contract period. The table below shows that, from state fiscal year (SFY) 2008 to SFY 2009, the static capacity of ID residential beds provided or contracted by CSBs increased by five.

CSB STATIC CAPACITY FOR INTELLECTUAL DISABILITY RESIDENTIAL SERVICES

Type of Residence	Number of Beds		Amount of Change
	SFY 2008	SFY 2010	
Supervised	465	467	+2
Intensive	779	794	+15
Highly Intensive	145	133	-12
TOTAL	1,389	1,394	+5

Sources: SFY 2008: Department of Behavioral Health and Developmental Services’ (DBHDS) staff. SFY 2009: DBHDS’ *2010 Overview of Community Services Delivery in Virginia*.

There are providers of ID residential services not represented in the table above because they are private providers under the ID Waiver and are not required to have a contract with a CSB. DBHDS reports that there were 962 group homes and 5,231 individuals residing in small community settings with one to 15 residents in 2009.

D. Available Community Housing Services and Programs

This section addresses both the specific types of housing options available to individuals with developmental disabilities and the programs which assist them in obtaining and maintaining housing. Each of the residential environments described differs with regard to housing structure, ownership, management, and operating costs. As a result, each requires a different approach to development and funding. The information in this chapter focuses on housing options that enable individuals to reside in communities with their families and friends and to avoid more-structured, restrictive “institutional” environments. Intermediate care facilities (ICFs) and nursing facilities, which are the principal kinds of highly intensive housing for people with disabilities in Virginia, are described in the Institutional Services chapter of this assessment.

Department of Housing and Community Development (DHCD): The following programs target Virginians with low to moderate incomes in general and, in some cases, individuals with disabilities in particular. Regardless of their emphasis, collectively these programs play a significant role in making safe, affordable, accessible housing available to persons with disabilities. Additional information on the programs described below can be found at the DHCD website or by contacting DHCD directly.

Housing Opportunities for Persons with AIDS (HOPWA) funding from the U.S. Department of Housing and Urban Development (HUD) supports the acquisition, rehabilitation, new construction, leasing, and operation of housing facilities for persons with low incomes who have been diagnosed with HIV/AIDS and their families. It also pays for rental and mortgage assistance, utility payment assistance, housing information, resource identification, technical assistance, and supportive services. HOPWA funds are distributed to local government housing agencies, public housing authorities, and health and human service agencies which, in turn, provide direct services for individuals and families who have applied through and been found eligible by local AIDS services organizations that coordinate service delivery. In state fiscal year (SFY) 2011, DHCD awarded \$700,000 in HOPWA funds for proposals selected through a competitive application process. Individual awards ranged from approximately \$45,000 to \$135,000.

The DHCD **Weatherization** program supplies funds to reduce heating and cooling costs for low-income families to ensure their health and safety. Households whose members include children, the elderly, and persons with disabilities are especially targeted. Services are delivered through a statewide network of community-based organizations that screen for eligibility, conduct energy audits, and install energy efficient measures in the home.

Individuals at imminent risk of homelessness caused by a crisis situation can receive temporary rental and mortgage assistance through the **Homeless Intervention Program (HIP)**. Individuals and families who are already homeless can receive assistance with security deposits and temporary rent payments to secure housing. Applications are submitted to local HIP administrators who determine eligibility and coordinate services.

Several programs address housing rehabilitation. **Federal Community Development Block Grants (CDBGs)** provide funding to eligible local governments for projects that address crucial community needs, such as housing, infrastructure, and economic development. Each project that utilizes CDBG funding must meet one or more national objectives. Funding through the **HOME Investment Partnership** is used to develop and rehabilitate transitional and permanent housing that serves low-income and special needs households and is available to government, nonprofit, and for-profit organizations. The **Emergency Home Repair Program** improves housing conditions and opportunities for Virginians with low and very low incomes. Repairs that will remove imminent health and safety hazards or eliminate barriers to habitability are covered by these funds. Assistance provided through local nonprofit agencies to housing occupants can include plumbing, structural, electrical, and roofing repairs as well as wheelchair ramps, accessible appliances, and other critical accommodations for people with disabilities.

The **HOMEownership Downpayment Assistance Program** makes purchasing a home more affordable for individuals and families with low to moderate incomes by assisting eligible borrowers with down payments and closing costs. The funds used for down payment and closing costs are administered through local partnerships with governmental entities, nonprofit housing service providers, and mortgage lenders across the Commonwealth. Currently, a statewide network of administrators is under contract with DHCD to offer housing counseling and intake services for prequalification screening for eligibility. The funds are provided on a first-come, first-served basis. The program structure promotes equitable access to the fund by entitlement and non-entitlement communities and is based on income and credit criteria.

Individuals lacking both the financial literacy skills and assets to achieve their goals of homeownership can obtain assistance through the **Virginia Individual Development Account (VIDA) Program**. This special savings program, typically offered through local governmental and nonprofit agencies, provides financial skills training, which includes assistance with the application process by local administrators. In addition, the VIDA program matches each dollar saved by the participant with two dollars. The combined savings can be used to purchase a home, start a business, or pursue postsecondary education.

The new **Neighborhood Stabilization Program** provides emergency assistance to state and local governments to acquire and redevelop foreclosed properties that might otherwise become sources of abandonment and blight within their communities. Funds can be used to purchase foreclosed or abandoned homes and to rehabilitate, resell, or redevelop these homes in order to stabilize neighborhoods and prevent a decline in neighboring homes' values. The July 2009 issue of *Opening Doors*, a housing publication for the disability community by the Technical Assistance Collaborative, Inc. (www.tacinc.org/downloads/OpenDoors_33.pdf),

details how this program can be used to create permanent supportive housing for people with disabilities.

Virginia Housing Development Authority (VHDA): Like those of the Department of Housing and Community Development (DHCD) described above, VHDA's activities target individuals and families with low to moderate incomes; however, VHDA may provide services for them both directly and through intermediaries. These include the **Access Virginia** website mentioned previously as well as outreach and training for developers and builders on *Americans with Disabilities Act* (ADA) accessibility requirements and the concepts of universal design, also described earlier. Other key VHDA programs are described below.

VHDA's **Homeownership Loan Programs** meet the changing needs of persons with low to moderate incomes by removing barriers to purchasing a home. VHDA home mortgage loans, usually originated by private lenders, are available for both first-time and repeat homeowners. Two traveling vans serve as **Mobile Mortgage Offices** to process and approve loans in the Southwest, Southside, and Eastern Shore regions of Virginia, areas not adequately served by traditional lenders. Since 1993, VHDA has also offered **Homeownership Education Classes** throughout the state to help Virginians learn the process of buying a home and maintaining it over the long-term. Classes are conducted in English, Spanish, and American Sign Language (ALS).

Multifamily Rental Loan Programs assist both large and small developers in purchasing, rehabilitating, and renovating apartments and other rental properties for Virginians with low to moderate incomes. **Federal Low-Income Tax Credits** are also available to encourage property owners to develop affordable rental housing.

VHDA's net revenues enable the **REACH Virginia** program to subsidize an array of targeted homeownership and rental funding programs. To qualify, Virginians must have incomes at or below 50 percent to 60 percent (varies by area) of the median income for the area in which they reside.

Previously known as "Certificates," "Section 8," or "Section 8 Existing," the "**Housing Choice**" **Voucher**, already mentioned several times in this chapter, is the latest name for the federal program that assists low-income families, the elderly, and individuals with disabilities with rental expenses. This "tenant-based" assistance is tied directly to the tenant and not to the property or structure. As noted in the access and delivery section above, 41 local Public Housing Agencies (PHAs) and 34 other local agencies overseen by VHDA receive funds from the U.S. Department of Housing and Urban Development (HUD) to administer the voucher program. Together, these agencies serve 112 Virginia counties and cities. As of January 2010, there were 47,833 vouchers authorized for use statewide, with VHDA administering approximately 20 percent (9,363) and the remainder administered by local PHAs.

Funds from VHDA's **Rental Unit Accessibility Modification** program are available to persons earning 80 percent or less of an area's median income. Grant funds are available on a

first-come, first-served basis, up to \$1,800 per dwelling unit, and can be used for any work needed to make the unit accessible for an individual with a disability. The application form for these funds is available on the VHDA website.

Granting Freedom is a partnership by VHDA, DHCD, Community Housing Partners, and other community groups that provides grant funds for modifications to make living spaces more accessible for Virginia servicemen and women who have sustained injuries in a combat theater of operations. Currently, more than \$1 million is available through this program to widen doorways and add ramps to make homes more wheelchair accessible, to install grab bars in bathrooms, or make other modifications that help eligible recipients feel more at home.

Department of Social Services (DSS): DSS Auxiliary Grants ensure that recipients of Supplemental Security Income (SSI) benefits, residing in a DSS licensed **assisted living facility (ALF)** or an approved adult foster care home, are able to maintain a standard of living that meets a basic level of care. Virginia regulations specify procedures for ALF licensure (22VAC 40-80-10 *et seq.*) and standards of care (22VAC 40-72-10 *et seq.*). The two main services covered by Auxiliary Grants are:

- Room and Board includes a furnished room in a building that meets all required fire safety codes; housekeeping services appropriate for the resident's needs; complete meals, snacks, and special diets, if necessary; and clean linens and towels as needed and at least once a week.
- Maintenance and Care services include minimal assistance with personal hygiene and grooming, including provision of personal supplies; administration of medications as required by licensing regulations; minimal assistance with the care of personal possessions and personal funds, if requested by the recipient and allowed by the facility; minimal assistance with telephones and correspondence; securing health care and transportation when needed; making appointments and arranging transportation; provision of social and recreational activities as required by licensing regulations; and general supervision for safety.

In addition to these basic services provided by an ALF or adult foster care home, Auxiliary Grants provide a personal needs allowance to the recipient. This allowance is used to cover medical expenditures such as copayments, prescriptions not covered by Medicaid, dental care, eyeglasses, and nonprescription over-the-counter medications; local and long-distance telephone service; personal transportation, clothing, toiletries, and other personal expenditures; and other needs outside of what are offered by the ALF or adult foster care provider. Regulations prohibit use of the allowance funds for recreational activities, administration of accounts, debts owed to the ALF for basic services, or laundry charges of more than \$10 per month.

Room, board, supervision, personal care, and other special services are provided to individuals in approved **adult foster care** homes. Policies relating to service delivery can be found in the 2011 DSS *Manual for the Provision of Adult Foster Care Services*

(www.dss.virginia.gov/files/division/dfs/as/as_intro_page/manuals/adult_fc/adultfostercareguide_1_2010.pdf).

Department of Behavioral Health and Developmental Services (DBHDS): DBHDS regulations (12 VAC 35-105-305 *et seq.*) describe **residential services** as a category of service providing 24-hour care in conjunction with treatment or training programs in a setting other than a hospital. Living arrangements vary from highly structured and intensively supervised environments to settings that provide for relative independence, requiring a modest amount of staff support and monitoring. Examples include, but are not limited to, residential treatment, group homes, supervised living, residential crisis stabilization, community geropsychiatric residential, community intermediate care facilities for persons with mental retardation (ICFs-MR), sponsored residential homes, medical and social detoxification, and substance abuse residential treatment for women and children.

Among the housing options for individuals with intellectual or developmental disabilities are the following, as described in the report of the General Assembly mandated housing study (2009 *Appropriations Act*, Item 315.Z) referenced in this chapter's introduction:

- **Group Homes:** In 2009, 62 percent of the recipients of Medicaid Home and Community Based Services (HCBS) Intellectual Disability (ID) Waiver services resided in DBHDS licensed group homes. There are a few state and federal programs available to help finance the development of new group homes. In particular, the federal Section 811 program provides both capital grants and ongoing operating subsidies to support group home development. The challenge is that small homes with four or fewer residents that conform to Virginia's and other states' model of community integration lack sufficient economies of scale to support ongoing feasibility at established provider rates. Consequently, there continues to be a predominance of larger homes. Resolution of this problem requires higher provider rates or supplemental funding assistance. Congregate housing costs are covered under the ID Waiver but not under the Individual and Family Developmental Disability (DD) Waiver.
- **Sponsored Residential Homes:** Called "host homes" in other states, this is a model of residential services in which a licensed provider contracts with a family, living in its own private residence, to share its family residence with up to two individuals with disabilities. In this setting, the family provides all of the supports that are prescribed in the individual's service plan and are subject to all of the regulations that apply to group homes. Sponsored residential homes are licensed as a congregate service, and therefore, not covered through the DD waiver.
- **Supervised Apartments:** Also called supportive in-home services, supervised apartments enable people with ID or DD to reside in mainstream housing. While Medicaid HCBS Waivers fund needed services and supports, there is no mechanism to provide assistance with shelter costs; therefore, housing providers are reliant on their ability to access scarce federal rent or operating subsidies in order to create new affordable supervised apartments.

More specific information on services covered under the ID and DD Waivers can be found in the Community Supports chapter of this assessment. Detailed information on public and private ICFs-MR can be found in the Institutional Services chapter.

E. Cost and Payment for Community Housing Services and Programs

Virginia and other states across the nation are pursuing a variety of cost-effective investment models to expand community housing choices for people with disabilities. A key element in successful efforts has been targeting state funds to fill critical funding gaps, stimulating investment of private capital to develop affordable housing. The size and nature of these funding gaps vary with the type of housing being developed; therefore, diverse funding strategies are needed to support different housing choices. These strategies were recognized in the report of the housing study recently called for by the General Assembly (2009 *Appropriations Act*, Item 315.Z):

“First, a number of states have appropriated funding for rent or operating assistance tied to specific newly created rental housing units—often a set-aside of units in rental housing receiving development subsidies through the federal Low-Income Housing Tax Credit (LIHTC) program. This has enabled state LIHTC administrative agencies to mandate set-asides of units in their LIHTC programs. Absent such state-funded assistance, many states, including Virginia, have provided incentives to developers in the competitive tax credit allocation process to encourage set-aside units for people with disabilities, but have not made such set-asides mandatory.

“Second, some states have created state rental voucher assistance programs for people with disabilities. Often assistance is targeted to Medicaid Waiver recipients to enable them to access affordable community housing without the multi-year wait time frequently necessary to participate in over-subscribed local Section 8 Housing Choice Voucher programs. State voucher assistance has expedited the use of Medicaid Waivers and facilitated the success of state Money Follows the Person initiatives. Absent such state funded assistance, it has been nearly impossible for Virginia to coordinate locally-managed federal Housing Choice Voucher waiting lists with state Medicaid Waiver waiting lists, thus making it extremely difficult to transition people from state institutions to community housing in a timely manner.”

Four state-level agencies and the U.S. Department of Housing and Urban Development (HUD) play key roles in developing and paying for community housing for people with disabilities in Virginia. Brief descriptions of their funding activities follow.

Department of Housing and Community Development (DHCD): Specific DHCD expenditures to provide services for individuals with disabilities are not available; however, in

state fiscal year 2010, federal funding for all DHCD programs providing services for individuals both with and without disabilities totaled \$71.3 million. Virginia provided \$11.2 million in additional funds for these programs.

As a result of action by the 2007 General Assembly, the **Livable Home Tax Credit** (www.dhcd.virginia.gov/HousingPreservationRehabilitation/Tax_credit_program.htm) mentioned in this chapter's introduction was expanded to include new construction and its administration was shifted from the Department of Taxation to DHCD. Using input from public comment forums held throughout Virginia, DHCD developed guidelines for the expanded credit that became effective on January 1, 2008. To be eligible for the tax credit, new homes must meet three key requirements: (1) have at least one zero-step entrance approached by an accessible route on a firm surface no steeper than a 1:12 slope proceeding from a driveway or public walkway, (2) have an accessible bathroom (can be a half-bath/powder room) on the same floor as the zero-step entrance, and (3) have doors with at least 32 inches of clear width and hallways/passageways of at least 36 inches of clear width to the accessible bathroom and eating area. The tax credit also applies to retrofitting of existing residential units to make them more accessible, regardless of whether an owner or resident has a disability requiring these visitability features and without income considerations. For new construction, the tax credit can be used by either the homebuilder or the home purchaser.

Virginia Housing Development Authority (VHDA): Specific expenditures by VHDA to provide services for individuals with disabilities are also not available. Funding for VHDA comes from federal sources, bond sales, and net revenues from its operations. It receives no state support.

Recipients of **Housing Choice Vouchers** are typically required to pay no more than 30 percent of their monthly rent, depending on the specific subsidy program. Federal funds distributed through VHDA are used by it and other local administrators to pay landlords directly for the balance of the contracted monthly rent.

Additional federal funds received by VHDA may be used to subsidize the cost of building affordable apartments by private developers, who can then charge lower monthly rents. As of October 31, 2010, the U.S. Department of Housing and Urban Development (HUD) classified 49.6 percent of the households served by VHDA as having a resident with disabilities.

Department of Social Services (DSS): State general funds constitute 80 percent of **Auxiliary Grants** to residents of DSS licensed **assisted living facilities (ALFs)** and **adult foster care** recipients. Localities must provide matching funds to make up the remaining 20 percent. DSS is responsible for dispersing state funds to local departments of social services, which then make payments directly to ALFs and adult foster care providers within their jurisdictions. The General Assembly sets the maximum rate for Auxiliary Grants and adjusts it periodically.

In addition to Virginia, 44 other states provide recipients of federal Supplemental Security Income (SSI) benefits with a variety of monetary supplements tied to various types of

residential settings that may serve persons with disabilities. Unlike some other states, Virginia's Auxiliary Grants are only available to residents of ALFs or adult foster care and do not provide supplemental funds for individuals living independently. As a result, the use of Auxiliary Grants, the only state-guaranteed housing assistance available to most Virginians with disabilities, is restricted to residential settings that are congregate and more institutional in nature.

Department of Behavioral Health and Developmental Services (DBHDS): Providers of Medicaid Home and Community Based Services (HCBS) Intellectual Disability (ID) Waiver services licensed by DBHDS are reimbursed by Medicaid for **residential services** provided that they are consistent with an individual's approved plan of care. Reimbursement rates are set by the Virginia Department of Medical Assistance Services (DMAS) with the approval of the Virginia General Assembly and are based on an hourly rate for an approved number of hours of service per month. Medicaid does not pay for room and board for community-based residential services. It reimburses only for actual services provided by residential staff according to the service recipient's Individualized Services Plan (ISP). Group home residents are typically assessed a client fee by their service provider. The client fee is a large percentage of the client's income, which in the majority of cases is limited to Supplemental Security Income (SSI) benefits.

U.S. Department of Housing and Urban Development (HUD): Every year, HUD offers community and faith-based organizations, local governments, and housing authorities across the nation the opportunity to compete for nearly \$2 billion in direct grants for housing-related projects. The following grants, categorized by program area, were awarded in Virginia between 2007 and 2010.

Section 202, Supportive Housing for the Elderly grants (www.hud.gov/offices/hsg/mfh/progdesc/eld202.cfm) to nonprofit organizations enable older individuals who meet income eligibility requirements to live independently. Funds cover capital expenditures for new construction or rehabilitation as well as rental assistance. Although Section 202 grants are competitive, the amount for each jurisdiction is determined by a "fair share" formula. In 2007, an 11-unit elderly housing complex in Woodstock received \$1.3 million for capital advances and \$118,500 in rent subsidies, and in 2010, \$5.3 million in capital advances and \$474,000 in rent subsidies were awarded for a 44-unit complex in Rocky Mount. Additional smaller awards brought Virginia's total for the period to \$9.2 million and \$1 million, respectively.

Section 811, Housing for Persons with Disabilities grants (www.hud.gov/offices/hsg/mfh/progdesc/disab811.cfm) to nonprofit organizations enable their target population to live independently by expanding the supply of affordable housing with supportive services. As for Section 202 grants, they pay for capital construction or rehabilitation and rental subsidies and are awarded competitively and distributed using a fair share formula. In 2010, a total of \$1.2 million in capital advances and \$108,000 in rent subsidies were awarded for a total of ten one-bedroom units, four in Danville and six in Fredericksburg, for persons with developmental disabilities.

Resident Opportunities and Self-Sufficiency grants (http://portal.hud.gov/hudportal/ HUD?src=/program_offices/public_indian_housing/programs/ph/ross) are awarded competitively to assist residents of public housing in becoming economically self-sufficient and to help the elderly and people with disabilities live independently. In 2007, a total of \$1.5 million was awarded to housing and redevelopment authorities and other agencies to provide public housing residents with education, job training, employment services, and homeownership counseling.

HOPE VI Revitalization of Public Housing grants (http://portal.hud.gov/hudportal/ HUD?src=/program_offices/public_indian_housing/programs/ph/hope6) are awarded to housing authorities to assist them in meeting capital costs associated with the replacement or major rehabilitation of severely distressed public housing complexes. In recent years, Congress has reduced annual funding for HOPE VI by more than 80 percent, from \$625 million in 1999 to \$120 million in 2009, and Virginia did not receive any grants in 2008 or 2009. Previously, the Danville Redevelopment and Housing Authority received a \$175,000 Mentoring Grant from this program in 2005.

Family Self-Sufficiency grants (http://portal.hud.gov/hudportal/ HUD?src=/program_offices/public_indian_housing/programs/hcv/fss) are awarded competitively to housing authorities for coordinators who help public housing residents with child care, job training, and job placement. The Virginia Housing Development Authority (VHDA) received a grant of \$192,000 for calendar year 2009.

Housing Counseling grants (www.hud.gov/offices/hsg/sfh/hcc/counselng.cfm) are awarded competitively to HUD-approved housing counseling agencies for free pre-purchase, post-purchase, default, and reverse mortgage counseling. Virginia organizations received \$2.4 million through this program in 2009.

Continuum of Care (CoC) grants (www.hud.gov/offices/cpd/homeless/programs/coc/) are awarded competitively to local partnerships of government agencies and nonprofit organizations that help homeless individuals and families find housing and supportive services. Virginia CoC programs received \$18.2 million in 2007, \$20 million in 2008, and \$20.8 million in 2009.

Fair-Housing Initiatives grants (http://portal.hud.gov/hudportal/ HUD?src=/program_offices/fair_housing_equal_opp/partners/FHIP/fhip) are competitively awarded to nonprofits for education and outreach activities promoting the federal *Fair Housing Act*. The Piedmont Housing Alliance in Charlottesville received \$62,212 in 2008 to continue its established, comprehensive initiative to inform the public about their rights and obligations under this statute.

HUD has stated that it is prioritizing initiatives that develop more livable and sustainable communities and build economic competitiveness by connecting housing with employment, quality schools, and transportation. Its new initiatives demonstrate a commitment to interagency

collaboration in policy development, programs, and funding to ensure better results for communities and better use of tax dollars. This new direction is encouraging; however, continued and strengthened engagement of the disability community is needed to ensure that people with disabilities are fully included and immersed in integrated community life.

F. Monitoring and Evaluation of Community Housing Services and Programs

Department of Housing and Community Development (DHCD): DHCD publishes a handbook containing the current *Virginia Residential and Landlord Tenant Act* (www.dhcd.virginia.gov/HomelessnessToHomeownership/PDFs/Landlord_Tenant_Handbook.pdf) which specifies the rights and responsibilities of tenants under a rental agreement. It also provides information on sources of legal assistance specializing in landlord and tenant issues. The **Virginia Office of Consumer Affairs** can also provide assistance on matters covered by this statute.

Virginia Housing Development Authority (VHDA): As an independent state public authority, VHDA is subject to oversight by the Governor and the General Assembly. The Governor appoints its eleven-member governing **Board of Commissioners**, which is required to submit an annual report to the Governor on its operating and financial status. VHDA annual financial statements are also subject to review by the state **Auditor of Public Accounts**.

Department of Social Services (DSS): The **DSS Division of Licensing Programs** has responsibility for protecting children and vulnerable adults in residential and daycare settings. It licenses assisted living facilities and adult daycare centers and has regulatory responsibilities covering family day homes, independent foster homes, child-placement agencies, and children's residential facilities. It also voluntarily registers family day homes that are not required to be licensed.

DSS Adult Protective Services (APS) investigates reports of abuse, neglect, and exploitation of incapacitated adults ages 18 and over and all adults ages 60 and over. Protective measures are initiated when warranted by the results of their investigations. **DSS Child Protective Services (CPS)** has equivalent responsibilities for children under age 18. Reports of abuse, neglect, and exploitation are directed to local departments of social services who conduct investigations and initiate protective measures. The goal of these protective services is to safeguard life, health, and property without loss of liberty. When this is not possible, assistance is provided with the least disruption of lifestyle, with full due process, and with protection and restoration of the person's liberty in the shortest possible time.

The *Code of Virginia* (63.2-1728) specifically requires DSS to establish a toll-free telephone line for complaints and to investigate all complaints received regarding the operations of assisted living facilities, adult daycare centers, and child welfare agencies, regardless of whether the program is subject to licensure. Those numbers are: Adult Protective Services, 888-

832-3858; Child Protective Services, 800-552-7096; and Division of Licensing Programs, 800-543-7545.

Investigations of licensing complaints may include onsite visits to inspect activities, services, records, and facilities and interviews with a facility's employees and agents and any persons within its custody or control. If a facility is found to be noncompliant, DSS must provide notice to the operator and may then take appropriate action as provided by law to ensure corrective action. The *Code of Virginia* (63.2-1808) details the rights of residents of assisted-living facilities, the responsibilities of their operators, and requirements for an annual review of residents rights.

APS investigations are confidential, and reports may be made anonymously. The investigation must include an in-person meeting with the alleged victim and contacts with others with knowledge of the individual or the circumstances, such as relatives, personal representatives, caregivers and facility staff. A disposition must be made within 45 days of the report. APS will only investigate if the individual is deemed to be "at-risk." If the individual has died or is no longer residing in or receiving services at the licensed facility or program, the at-risk criterion is not met.

Department of Behavioral Health and Developmental Services (DBHDS): The regulatory and oversight of responsibilities of DBHDS for public and private residential facilities and services that it licenses or funds are covered extensively in the monitoring and evaluation section of the Community Supports and Institutional Services chapters of this assessment. These chapters also include information on the **Office of the Inspector General (OIG) for Behavioral Health and Developmental Services**. Information on the DBHDS **Office of Human Rights**, including a specific listing of statutory rights, can be found in both the Community Supports chapter and in the Advocacy Information and Resources appendix.

Department of Professional and Occupational Regulation (DPOR): Public awareness and enforcement of the state's fair housing law is the responsibility of DPOR's **Virginia Fair Housing Office (VFHO)**, which serves as the investigative arm of Virginia's **Fair Housing Board (FHB)** and **Real Estate Board (REB)**. The FHB administers and enforces the fair housing law for most individuals and businesses, while the REB retains jurisdiction over real estate licensees and their employees. The FHB is also charged with establishing a fair housing certification program applying to non-licensed property managers, leasing consultants, and homeowners who are involved in selling or renting dwellings. Both boards meet at the DPOR offices in Richmond, and the public is welcome to attend their meetings.

The state's first fair housing law, enacted by the General Assembly in 1972, was initially similar to the fair housing provisions of the national *Civil Rights Act* of 1968; however, amendments over time have extended its coverage to protect additional classes of individuals making it broader than the federal law. Virginia's fair housing law prohibits discrimination on the basis of race, color, religion, national origin, sex, familial status, "handicap," and

“elderliness.” Elderliness, which refers to anyone who is age 55 or older, is not a covered protected class under the federal law.

Individuals who feel they have been discriminated against or that fair housing laws have been violated report their complaints directly to the VFHO. Its staff investigate the allegations by conducting interviews with the complainants, respondents, and relevant witnesses and by reviewing appropriate records and other documents.

Once the investigation is complete, a final report is completed that summarizes the evidence obtained. That report and the evidence are presented to the FHB or REB, whichever is appropriate, at its next regularly scheduled meeting. Following the FHB or REB’s review of the evidence, it can issue a “no reasonable cause” finding or a “reasonable cause” finding. If it finds no reasonable cause, both parties are notified in writing, and no further action is taken. If there is a finding of reasonable cause, the parties have 30 days to engage in conciliation attempts.

Conciliation is a voluntary process in which the parties attempt to come to a mutually acceptable agreement. If conciliation is successful and approved by the FHB or REB, the investigation is suspended. If one or both parties reject conciliation or they are unable to resolve the complaint through the conciliation process, a charge is issued and immediately referred to the state Office of the Attorney General for further action. Both parties involved are notified accordingly, in writing.

In fiscal year 2010, the VFHO investigated and closed 103 cases. Conciliation was successful in approximately 20 percent of these cases, resulting in awards to complainants of approximately \$41,000.

In addition to investigating and settling complaints, the VFHO conducts outreach and training on fair housing laws. These activities range from distribution of handouts to sophisticated interactive presentations by the VFHO staff to state and local officials, housing providers, and consumers. This training is offered free and is tailored to meet the specific needs of its recipients.

G. Community Housing Services and Programs Sources Referenced in This Chapter

Links to websites and online documents reflect their Internet addresses in March 2011. Some documents retrieved and utilized do not have a date of publication.

Websites:

Access Virginia:

www.accessva.org

National Low Income Housing Coalition:

www.nlihc.org

- Transportation and Housing Alliance Toolkit:
www.tjpd.org/housing/thatookit.asp
- U.S. Department of Housing and Urban Development:
<http://portal.hud.gov/portal/page/portal/HUD>
- U.S. Social Security Administration:
www.ssa.gov/policy/docs/statcomps/di_asr/2009/sect01.html#chart2
- Virginia Department for the Aging:
www.vda.virginia.gov
- Virginia Department of Behavioral Health and Developmental Services (DBHDS):
www.dbhds.virginia.gov
- Virginia Department of Housing and Community Development (DHCD):
www.dhcd.virginia.gov
- Virginia Department of Medical Assistance Services:
www.dmas.virginia.gov
- Virginia Department of Professional and Occupational Regulation:
www.dpor.virginia.gov/dporweb/dpormainwelcome.cfm
- Virginia Department of Social Services (DSS):
http://www.dss.virginia.gov/files/about/reports/adults/adult_services_annual/2010.pdf.
- Virginia Housing Development Authority (VHDA):
www.vhda.com
- Virginia Housing Policy:
www.virginiahousingpolicy.com
- Virginia Olmstead Initiative:
www.olmsteadva.com
- Virginia Statewide Independent Living Council (SILC):
www.vasilc.org
- Virginia Uniform Assessment Instrument:
www.cdaaa.org/images/UAI.pdf

Documents:

- Code of Virginia, 37.2-404 et seq. Authority for Establishment of Rules and Regulations for the Licensing of Providers of Mental Health, Mental Retardation and Substance Abuse Services.* Retrieved from: <http://lis.virginia.gov/cgi-bin/legp604.exe?000+cod+37.2-404>.
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X. Transportation

A. Introduction

The *Americans with Disabilities Act* (ADA, 42 USC 12101 et seq.) and the *Virginians with Disabilities Act* (51.5-44) stipulate that people with disabilities have the same rights as other persons to the full, free use of the streets, highways, sidewalks, and all other parts of the transportation system. For people with disabilities, the *Code of Virginia* (54.1-44[B]) further requires “full and equal accommodations, advantages, facilities, and privileges of all common carriers, airplanes, motor vehicles, railroad trains, motorbuses, streetcars, subways, boats, or any other public conveyances or modes of transportation.”

The *2010-2012 Strategic Plan* for the Commonwealth’s **Department of Rail and Public Transportation (DRPT)** states that: “80 percent of Virginians now live in jurisdictions that have transit services, compared to 73 percent in 2003. Nineteen new transit programs and service expansions have been added since 2003, and DRPT has completed several significant planning and needs studies that will help improve public transportation in Virginia.” In its strategic plan, DRPT further notes that the lack of access to public transportation for the remaining 20 percent of the population makes it difficult for many to participate in everyday activities such as going to the grocery store, receiving medical care, or obtaining employment.

The DRPT plan also notes that the growth and aging of Virginia’s population continues to impact the state’s need for transportation services. Virginia’s population has grown 16 percent over the past ten years, and an additional increase of 20 to 30 percent is anticipated by 2025. The percent of the population over age 65 is expected to grow from 11.7 percent in 2000 to approximately 18 percent in 2025.

In addition to being guaranteed access to basic transportation systems, as required by law, Virginians with disabilities are served by specialized transportation systems. These include regularly scheduled **accessible transit services**, “**paratransit**” or “**demand-response**” **services**, and **emergency and nonemergency human service transportation** available through publicly funded insurance programs or from disability services providers.

Since the passage of the *Americans with Disabilities Act* (ADA), paratransit service has grown rapidly as a mode of public transit across the nation, and continued growth can be expected due to the aging of baby boomers. Some estimates suggest paratransit ridership could double during the next ten years. The American Public Transportation Association (www.apta.com) defines paratransit as:

“...transportation that is characterized by the use of passenger automobiles, vans, or small buses operating in response to calls from passengers or their agents to the transit operator, who then dispatches a vehicle to pick up the passengers and transport them to their destinations. The vehicles do not operate over a fixed route or on a fixed schedule. The vehicle may be dispatched to pick up several

passengers at different pick-up points before taking them to their respective destinations and may even be interrupted en route to these destinations to pick up other passengers.”

For a number of years, Virginia has emphasized development of coordinated human service transportation models that include a broad range of services designed to meet the needs of populations who need transportation options beyond a personal automobile, particularly older adults, people with disabilities, and people with lower incomes. Depending on their abilities, their environment, and the transportation services available in their communities, these individuals may require a variety of mobility options. Examples include transportation services provided by human service agencies for people participating in their programs, “dial-a-ride” paratransit services, taxi voucher programs, and transportation services provided through volunteer drivers.

DRPT has taken the lead in statewide efforts on human service transportation coordination. Its *State Coordination Model for Human Service Transportation* report, released in April of 2010, provides some new, useful data regarding coordination efforts, needs and action plans. Many of these initiatives emanated from the federal directives and incentives described below.

Presidential ***Executive Order 13217, Community-Based Alternatives for Individuals with Disabilities***, issued on June 18, 2001, called on the federal government to assist states and localities with enforcement of the landmark U.S. Supreme Court decision in *Olmstead v. L.C.* (www.law.cornell.edu/supct/html/98-536.ZS.html). In 2004, Presidential ***Executive Order 13330, Human Service Transportation Coordination***, further clarified the federal government’s vision that “comprehensive and coordinated community transportation systems are essential for persons with disabilities, persons with low incomes, and older adults who rely on such transportation to fully participate in their communities.” Emphasizing the need for compliance with the *Olmstead* decision, President Obama marked its tenth anniversary on June 22, 2009 by designating the next year as “The Year of Community Living.”

The **United We Ride State Coordination Grant** and the ***Safe, Accountable, Flexible, Efficient Transportation Equity Act: A Legacy for Users*** (SAFETEA-LU, 23 USC 101 *et seq.*) federal initiatives were created in response to these executive orders. The United We Ride State Coordination Grant obtained by DRPT in 2004 was used to establish a clear and objective baseline for the Commonwealth’s human service transportation resources, determine current levels of coordination in communities across the state, and assess unmet needs. In 2009, DRPT submitted a funding proposal to the Federal Transit Administration (FTA) in response to its announcement of the United We Ride Mobility Management Grant opportunity. Later that year, DRPT was one of six successful applicants to receive a grant. Implementation of activities funded by the grant began in 2010 and will continue into 2011. DRPT’s activities under SAFETEA-LU are discussed further in the cost and payment section of this chapter.

In support of state and local efforts and in response to extensive public comment in this area, the **Virginia Board for People with Disabilities (VBPD)**, author of this assessment, has had a long-standing focus on improving transportation options for individuals with disabilities. The Board believes that self-determination, independent living, and full community inclusion can only be accomplished when planners and managers at the local and statewide levels develop a system of mutual responsibility for communication, coordination, and collaboration that integrates housing and transportation in ways that meet the unique needs and overlapping interests of people with disabilities.

To promote interagency collaboration, the VBPD awarded the **Transportation and Housing Alliance (THA)** grant to the Thomas Jefferson Planning District Commission (TJPDC) in June 2004. Through the THA, planners and developers engaged in providing housing and transportation for persons who have disabilities, have low incomes, or are elderly were brought together to get to know and educate one another by sharing information, resources, and technical assistance. A follow-up grant from VBPD to TJPDC produced an innovative **THA Toolkit** (www.tjpd.org/housing/THAtoolkit.asp). This data collection and analysis tool, which uses state-of-the-art mapping technology, makes it easier for localities to integrate information on current and projected housing and transportation capacity, improving their ability plan and coordinate the two. A second follow-up grant funded the use of the toolkit by 12 sub-grantees between July 2007 and June 2009 and further refined its capabilities using their feedback. These projects have resulted in public policy recommendations at the local and state levels to improve and expand communities' housing and transportation infrastructure.

A third extension of the THA Toolkit grant, from October 2010 through March 2012, will market and promote its use and develop an assessment tool and model language for ordinances and regulations. TJPDC will review zoning ordinances, subdivision regulations, and development review processes of a representative sample of its member localities to identify barriers in these regulatory instruments, then model language that localities can adopt to address them. The goal of this process is to persuade local elected officials and staff of the importance of incorporating inclusive principles to fully integrate transportation and housing planning and accessibility for their communities.

A variety of state entities are involved with providing transportation services for Virginians with disabilities. The **Virginia Department of Transportation (VDOT)** is the Commonwealth's chief agency for transportation planning and for the construction, maintenance, and operation of its highway systems and related infrastructure; however, while extremely important, VDOT's role in providing service to people with disabilities is largely indirect. VDOT's mission is to "plan, deliver, operate, and maintain a transportation system that is safe, enables easy movement of people and goods, enhances the economy, and improves our quality of life." It is responsible for ensuring that Virginia's state-maintained highway system, the third largest in the country after North Carolina and Texas, is compliant with the federal *Americans with Disabilities Act (ADA)*, but it has no programs, projects, or initiatives specifically targeted to serving the transportation needs of people with disabilities.

With its mission “to improve the mobility of people and goods while expanding transportation choices in the Commonwealth,” the **Virginia Department of Rail and Public Transportation (DRPT)** plays a key role for Virginians both with and without disabilities. It provides financial and technical assistance to more than 160 public transportation operators, health and human service providers, commuter assistance agencies, and railroad operators in the state. The *Code of Virginia* (33.1-391.1-391.5) identifies 14 specific responsibilities for the agency, under the categories of “economic and financial analysis capabilities, accountability, planning and programming, and coordination.” As noted in its 2010 report, *State Coordination Model for Human Service Transportation*, cited earlier, DRPT:

“...seeks to establish a clear vision at the state level for enhanced coordination of human service transportation and to develop a realistic state model to lead coordination efforts. This effort is critical as DRPT looks to use funding resources the agency administers as efficiently as possible, while building upon current coordination activities with other state agencies which also oversee programs that fund transportation services for older adults, people with disabilities, and people with lower incomes.”

DRPT’s *2010-2012 Strategic Plan*, also cited earlier, further describes its initiatives to improve and expand human service transportation programs in the Commonwealth as:

“...operated by local government social service agencies or private non-profit human service agencies for the benefit of their clients. These clients are elderly, have disabilities, or are economically disadvantaged children who are enrolled to receive publicly funded social services. Human service transportation differs from public transportation in that it is designed to serve the very specific needs of human service agency clients and, in most cases, service is restricted to the clients of those agencies who often have no other transportation service available to them. It is not open to the public.”

DRPT’s **Public Transportation Division** administers and manages state and federal grant programs, such as state operating-assistance grants, capital assistance grants, and special projects grants; conducts performance evaluations; provides technical assistance; and works to support ride-sharing operations and alternate commuting options. The advice, technical support, and funds for passenger rail and public bus operators, including paratransit services, that DRPT provides are of particular importance to transportation services for people with disabilities. The **Rural Transit Section** within its Public Transportation Division manages rural and specialized grant funds provided by the Federal Transit Administration (FTA).

DRPT’s *State Coordination Model for Human Service Transportation* also calls attention to other state agencies that play significant roles in providing and monitoring human service transportation. In particular, as described in an earlier chapter of this assessment, the **Virginia Department of Medical Assistance Services (DMAS)** is the state’s designated agency for administration of Medicaid. As such, it has the responsibility under Title XIX of the *Social Security Act* (42 USC 1396 *et seq.*) to assure that necessary emergency and nonemergency

transportation is available, when necessary, to approved providers of services covered by Medicaid.

Brief descriptions of the human service transportation services provided by other agencies, some at least in part through DRPT resources or the Medicaid brokerage system, are listed below.

<u>State Agency</u>	<u>Role in Human Service Transportation</u>
Department for the Aging (VDA)	Provides funding for transportation services operated by local Area Agencies on Aging (AAAs).
Department for the Blind and Vision Impaired (DBVI)	Purchases transportation for individuals to participate in vocational rehabilitation services.
Department of Behavioral Health and Developmental Services (DBHDS)	Has authority for mental health, intellectual disability, and substance abuse services. Oversees Community Services Boards (CSBs) that may use funding for transportation in association with allowable services.
Department of Rehabilitative Services (DRS)	Purchases transportation for individuals to participate in vocational rehabilitation services.
Department of Social Services (DSS)	Oversees local departments of social services, including programs that can fund transportation services.

B. Eligibility for Transportation Services

Public Transportation: With the passage of the *Americans with Disabilities Act (ADA)* in 1990 and its subsequent amendment in 2008, **all activities of state and local government are required to be accessible to people with disabilities.** Accessibility is not limited to programs receiving federal funds, as required by Section 504 of the *Rehabilitation Act (29 USC 794)*. Under ADA, public transit services, regardless of how they are funded or managed, must be accessible. Transit providers may meet accessibility requirements through the use of **paratransit** services, either on existing fixed routes or on a **demand-response** basis. Eligibility for paratransit service typically requires verification of a disability.

Medicaid-Funded Transportation: When individuals who are eligible for Medicaid do not have other access to transportation, their transportation to and from approved providers of medically necessary services are covered under Virginia's **Medicaid State Plan and State Children's Health Insurance Program (SCHIP)**. Additional information on Medicaid and SCHIP eligibility can be found in the Medicaid chapter of this assessment or obtained from the

Department of Medical Assistance Services (DMAS, <http://dmasva.dmas.virginia.gov/default.aspx>).

In addition to its other eligibility requirements, the Medicaid State Plan has two major guidelines for providing and covering transportation services. Under the **“mobility” guideline**, transportation is provided and covered if the Medicaid recipient either does not own an operable automobile or cannot operate one safely and has no other transportation available from a spouse or, in the case of a minor, a custodial parent. Spouse or parent drivers must have a valid operator’s license, and the vehicle must be properly registered, inspected, in operable condition, and available for use at the time of the appointment. Exceptions to the “no other transportation available” provision must be made for individuals going to dialysis treatment, chemotherapy, or radiation therapy; recipients of foster care; or enrollees in a **Medicaid Home and Community Based Services (HCBS) Waiver**. An additional exception is possible when the length or frequency of a trip, or trips, would impose a financial burden on the recipient or the recipient’s family.

Under the **“eligible purpose” guideline**, transportation is provided so that services covered by Medicaid can be received. If the service requires preauthorization by DMAS or its agent, the recipient must obtain that preauthorization before requesting transportation to travel to the service or for any follow-up visits. Chapter IV of the DMAS Transportation Manual (www.dmas.virginia.gov/tra-transportation_services.htm) contains detailed information on coverage and eligibility for transportation services.

Human Service Transportation: Eligibility for these transportation services varies based on the service being provided, the agency providing the service, and the source of funding. As shown in the table at the end of this chapter’s introduction, local Area Agencies on Aging (AAAs) and Community Services Boards (CSBs) often provide transportation as a Medicaid-reimbursed provider. Eligibility is based on the specific program or local requirements. Similarly, the Department of Rehabilitative Services (DRS) and the Department for the Blind and Vision Impaired (DBVI) can purchase transportation if it is needed for an individual participating in their vocational rehabilitation programs to access agreed upon services. Eligibility for DRS and DBVI vocational rehabilitation programs is covered in the Employment chapter of this assessment.

As noted above, individuals who receive services under a Medicaid HCBS Waiver are eligible for human service transportation services subject to the rules of their particular waiver. For example, under the Individual and Family Developmental Disability (DD) Waiver, transportation may be provided to and from any service authorized under the DD Waiver, such as to and from an individual’s place of residence or other designated location and an enrolled waiver services provider of supported employment or day support. Each waiver has specific eligibility requirements and criteria for services that are detailed in the Medicaid chapter of this assessment.

Additional, user-friendly information on human service transportation can be found at the **Virginia Easy Access** website (www.easyaccess.virginia.gov/transportation.shtml).

C. Access to and Delivery of Transportation Services

Public Transportation: Buses, trains, and other means of public conveyance usually operate on fixed routes with stops at specified times or time intervals. As indicated in the eligibility section above, when individuals with disabilities are not able to use these services, the *Americans with Disabilities Act* (ADA) requires that they be served by **paratransit or demand-response services**. Those services may be provided directly by the transit system itself or through a separate operator. As of March 2011, there were 79 public transit providers listed in the Department of Rail and Public Transportation (DRPT) statewide database (www.drpt.virginia.gov/locator/allproviders.aspx?type=3).

For paratransit and demand-response systems, the rider or someone acting on his or her behalf typically calls a reservation agent to schedule a pickup day and time. The caller must inform the agent of any special circumstances or needs such as the need for a wheelchair-accessible van or an attendant accompanying the rider. Times of operation and requirements for advance notice of a pickup vary widely among localities. Most services require notice at least 24 hours in advance, and some providers have penalties for late notice or frequent trip cancellations. Transportation service providers in a rider's locality should be contacted directly for details.

Medicaid-Funded Transportation: Access to health care for Medicaid recipients is highly dependent on a reliable network of transportation providers, and in Virginia, the **Department of Medical Assistance Services (DMAS)** is responsible for creating and managing this network. To do so, it solicits and contracts with a **Medicaid transportation broker** that then contracts with individual community agencies or private providers for transportation services for people with disabilities. The transportation broker is responsible for establishing and maintaining a safe, sufficient, and reliable network of providers of nonemergency Medicaid-funded transportation. In addition, the broker determines a rider's eligibility in compliance with DMAS guidelines, verifies his or her need for transportation services, determines the most appropriate mode of transportation to meet the rider's needs, authorizes the transportation service, and arranges trips with the subcontracted transportation providers.

To receive reimbursement for nonemergency Medicaid trips, transportation providers must have a contract with the Medicaid transportation broker. The broker is encouraged by DMAS to contract with Community Services Boards (CSBs), private providers of intellectual and developmental disabilities services, Area Agencies on Aging (AAAs), and other community-based organizations that provide disability-related transportation services. DMAS requires that all transportation providers comply with the *Americans with Disabilities Act* (ADA) and the *Rehabilitation Act* of 1973, as amended (29 USC 791 *et seq.*), and requires the broker to ensure, to the greatest extent possible, that service recipients have stable and consistent transportation

services with regular drivers. With prior approval from DMAS, these community-based providers may restrict their transportation services to the specific populations that they serve.

Unless it is an urgent trip, to arrange for Medicaid-funded transportation, an eligible individual, relative, caregiver, or medical facility staff member must call the broker reservation line at least five days in advance. The broker obtains information about the rider's health condition and physical limitations, then determines the appropriate pickup time, based on that information as well as the expected travel time, in order to arrive at the scheduled service on time. Verifiable urgent trips, such as sudden illness or hospital discharges, may be accepted with less than five days' notice. For recurring appointments, such as dialysis or day supports funded through a Medicaid Home and Community Based Services (HCBS) Waiver, the transportation is scheduled in advance and continues until the broker is instructed to cancel it. The broker refers to such appointments as "standing orders" or "prescheduled trips."

Individuals who are deaf, hard of hearing, deafblind, or speech disabled can access a free public service, **Virginia Relay**, with a standard telephone to schedule transportation. Relay services are available 24 hours a day, 365 days a year, with no limit on the number or length of calls a user may make. Anyone can initiate a Virginia Relay call by dialing 7-1-1. After reaching Virginia Relay, callers give the Virginia Relay Communications Assistant the phone number of the person or business that they wish to contact. Once a connection has been made, the Communications Assistant relays the conversation between the two parties. More information on Virginia Relay appears in the Community Supports chapter of this assessment or can be found at www.varelay.org.

DMAS has been promoting alternative means of nonemergency transportation to augment existing Medicaid transportation options and better support the needs and circumstances of individual service recipients. Fixed-route, not paratransit, public transit is the most desirable alternative, when possible and feasible, because it can increase passenger mobility significantly. Two other alternatives have been successful in increasing transportation capacity in other states, especially in rural or isolated areas. In the **Volunteer Driver Program**, trained volunteers, assigned by the transportation broker, transport eligible recipients to Medicaid-funded services in their own approved vehicles and are reimbursed for mileage. Information on this service, including becoming a driver, is available by telephone from the nonemergency transportation broker at 866-810-8305 (toll-free). In the **Gas Reimbursement Program**, a family member or friend of the individual needing to go to a medical appointment or other Medicaid-funded service can obtain advance approval from the broker to drive that individual and be reimbursed for mileage. Information on this program is available at 866-809-4620, extension 600 (toll-free).

According to information provided by DMAS, approximately 260,000 Virginians are eligible for nonemergency transportation services in any given month. Of these, typically 21,000 individuals actually utilize these services each month and about 50,000 unduplicated individuals use them in the course of a year. In state fiscal year (SFY) 2009, approximately 3.7 million one-way nonemergency transportation trips were made throughout the Commonwealth.

D. Available Transportation Services

Before continuing with his chapter's focus on public transit and human service transportation services, it is important to note that **adaptive driving** and **vehicle modifications** are an important transportation option for many individuals with disabilities. Adaptive driving allows an individual with a disability to drive as well as an individual who does not have disabilities, and the organization Infinite Potential Through Assistive Technology (www.infinitec.org) notes that "just about any vehicle can be adapted if the vehicle fits the driver. Some drivers will need a two-door car, while others find more flexibility in a four-door, and still others will require a van or sports utility vehicle."

The first step to vehicle modification for adaptive driving is to obtain a reliable assessment by a driving rehabilitation specialist. This assessment determines whether the individual, with appropriate adaptive aids, can drive safely. A list of local vehicle modification dealers is available from the National Mobility Equipment Dealers Association (NMEDA, 813-932-8566 or www.nmeda.org).

Public Transportation: The vast majority of scheduled, fixed-route transit services use buses or trolley-buses on public streets and highways. **Paratransit services** are required by law for persons with disabilities who are not able to use fixed-route services and, generally, use smaller specially equipped vehicles such as vans or minibuses and specially trained operators. Paratransit must operate in the same areas and during the same hours as fixed-route services, and their fares can be no more than twice the fixed-route fares.

Demand-response services, which operate outside of a locality's public transit system hours or in areas where public transportation is not available, are not legally mandated and are not subject to either the route and schedule requirements or fare restrictions for paratransit services. Vehicles may be dispatched to pick up several different passengers at several different points before taking them to their respective destinations, and they may even be diverted in route to these destinations to pick up additional passengers. Services may be limited to certain target populations, areas, or times. Some localities use demand-response services during late-night and weekend hours in place of fixed-route services.

In "**user-side subsidy**" services, a rider's cost of transportation is partially subsidized by a transit agency. The rider is the "user" who pays a reduced fare for the services. A typical user-side subsidy program uses taxicab operators or a brokerage system that may charge a per-ride fee for handling the rider's transportation arrangements.

Medicaid-Funded Transportation: Transportation services covered by Virginia's Medicaid programs are categorized as "**emergency ambulance**" and "**nonemergency**." Emergency ambulance transportation covers situations such as heart attacks and life-threatening injuries. It does not include service for minor abrasions, lacerations, bruises, fever, normal labor pains, headaches, intoxication, or other conditions that are not life-threatening and are categorized as

nonemergency. Nonemergency transportation services are provided through the brokerage system introduced earlier in this chapter and described in more detail below.

In nonemergency situations, the Medicaid transportation broker determines the appropriate level of service needed for a safe pickup and delivery of the recipient to his or her destination. **Curb-to-curb service** is provided for individuals who need little, if any, assistance from the door of the pickup point or destination to the vehicle. In some cases, transportation service recipients are transported **hand-to-hand**; that is, a person at the pickup point passes the recipient into the hands of the driver who will transfer the recipient into the hands of a facility staff member, family member, or other responsible party at the destination. Examples of individuals who may require this level of service include those with dementia or significant cognitive disabilities.

For Medicaid recipients living in areas with transit systems, the transportation broker can provide tickets or passes for use on fixed-route public transportation. **Travel training** may also be provided for recipients who require it. If a recipient does not own a car or cannot drive, the broker may reimburse preapproved gasoline expenses to a spouse or to a parent, guardian, or foster parent of a minor child for driving the recipient to an appointment. Ambulatory recipients may be transported by cars or minivans, including taxis, arranged by the broker. Wheelchair users are transported in lift-equipped vehicles, and those who must remain prone are transported by nonemergency ambulance or by stretcher transportation.

In some cases, Medicaid may also cover transportation-associated costs such as meals, overnight lodging, and an attendant. With prior approval by the DMAS Medicaid Support Unit, transportation is also provided out-of-state when a medically necessary service cannot be provided in Virginia.

E. Cost and Payment for Transportation Services

Virginia Department of Transportation (VDOT): VDOT's annual budget for state fiscal year (SFY) 2011 is \$3.32 billion, a 1.6 percent decrease from the previous year; however, with the exception of ensuring compliance with the Americans with Disabilities Act (ADA) for all its highway-related facilities, VDOT does not provide or fund services specifically targeted to people with disabilities. Its funds are used for building and maintaining highways and related facilities, mass transit, airports, seaports, payments to localities for maintaining their own roads, and administration. Funds are also allocated for debt payments, operations, maintenance, and improvement costs for the state's toll roads. Details of VDOT's budget and revenue sources can be found at www.vdot.virginia.gov/about/vdot_budget.asp.

Virginia Department of Rail and Public Transportation (DRPT): The Commonwealth does not mandate or provide any state funding for coordination of transportation services; however, the **Federal Transit Administration (FTA)** does require that DRPT assure that recipients of federal transportation grants have provided for maximum coordination of transportation services.

As result, DRPT has made coordination of transportation services the most important goal of the state's **Section 5310** program.

FTA Section 5310 funds are used by local agencies to purchase capital equipment for transportation services for the elderly and persons with disabilities in areas where those services are unavailable, insufficient, or inappropriate to their needs. They cannot be used for operating expenses.

DRPT is responsible for ensuring that local applicants for Section 5310 funds and their projects are eligible for the funds and in compliance with federal requirements, that private nonprofit transportation providers have an opportunity to participate as feasible, and that the program provides for as much coordination of federally assisted transportation services as possible. Section 5310 funds are obligated based on an annual program of projects included in a statewide grant application submitted to the FTA by DRPT and are distributed by DRPT using a formula based on the size of the population of individuals who are elderly or have disabilities.

In its strategic plans, DRPT reports that it received \$2,832,364 in Section 5310 funding in fiscal year 2009 and awarded grants to 39 recipients for the purchase of 66 vehicles. In 2010, it received \$3,037,891 in funds for grants to 36 recipients for 76 vehicles. All vehicles purchased using DRPT's Section 5310 funds in fiscal year 2010 were fully accessible for persons with disabilities, and DRPT continues to require all organizations to purchase accessible vehicles with removable regular seating that help to maximize space to meet the needs of their service populations.

DRPT's Rural Transit Section manages FTA **Section 5311** grants for public transportation in areas with fewer than 50,000 residents. Section 5311 funds are used for capital expenditures and may also be used to cover administrative and operating costs. Eligible entities include state and local governments, transportation district commissions, nonprofit organizations, and public service corporations. They can be used to pay up to 90 percent of the cost of projects that meet the requirements of the *Americans with Disabilities Act (ADA)* or *Clean Air Act* or address bicycle access.

In 2005, the U.S. Congress passed the *Safe, Accountable, Flexible, Efficient Transportation Equity Act: A Legacy for Users (SAFETEA-LU)*, first mentioned in this section's introduction, which reauthorized the federal *Surface Transportation Act*. Under SAFETEA-LU, DRPT administers the **Job Access and Reverse Commute (JARC) Program** and the Section 5317 or **New Freedom Program**. The JARC Program develops transportation services to and from suburban employment opportunities for welfare recipients and individuals with low incomes living in rural and urban areas. The New Freedom Program funds public transportation services beyond the ADA requirements and for new public transportation alternatives for people with disabilities.

DRPT's *2010-2012 Strategic Plan* notes that, in addition to its Human Service Agency Capital Grants, which include the federal Section 5310 and 5317 funds described above, it

manages Public Transportation Paratransit Capital Grants that use state funds to support procurement of vans and small buses used in demand-response transport of individuals who are elderly, have a disability, or are economically disadvantaged. It also funds and provides training, expert advice, and technical assistance for operators of human service transportation regarding defensive driving, wheelchair lift operations and wheelchair securement, vehicle and lift preventive maintenance, and working with people with disabilities.

Public Transportation: The Commonwealth ranks 12th in the nation in total state spending on public transportation and 14th in per capita spending. It is also one of 17 states with commuter rail service. Funds supporting local public transportation systems in Virginia come from a mixture of federal, state, and local government sources, as well as operating revenues. Except as noted for Medicaid-funded and user-side subsidized services, individuals are responsible for payment of public transportation fares. Local transportation service providers can be contacted for further information.

Medicaid-Funded Transportation: The Medicaid transportation broker is responsible for all nonemergency transportation services provided to Medicaid recipients, whether they were served by a traditional fee-for-service program or enrolled in a capitated managed care organization. Transportation providers are paid by the broker at negotiated rates, and they cannot obtain additional reimbursements from the transportation recipient or the recipient's family. For state fiscal year (SFY) 2010, the Department of Medical Assistance Services (DMAS) reports that 3,739,063 one-way nonemergency transportation trips were made at a cost of \$72,168,973.

Human Service Transportation: The table below shows agency funding for human service transportation for state fiscal year (SFY) 2009. It is the latest annual information available and was obtained from DRPT's *State Coordination Model for Human Service Transportation* report.

ESTIMATED ANNUAL HUMAN SERVICE TRANSPORTATION FUNDING

<u>State Agency</u>	<u>SFY 2009 Funding</u>
Department of Rail and Public Transportation (DRPT)	
Section 5310	\$3,143,000
Section 5316	\$2,923,856
Section 5317	\$1,368,247
<u>Senior Transportation</u>	<u>\$119,059</u>
DRPT Total	\$7,554,162
Department of Medical Assistance Services (DMAS)	\$70,530,228
Department of Rehabilitative Services (DRS)	\$644,635
Department for the Blind and Vision Impaired (DBVI)	\$172,215
Department for the Aging (VDA)	\$6,024,806
<u>Department of Social Services (DSS)</u>	<u>\$6,656,032</u>
<u>TOTAL</u>	<u>\$91,582,078</u>

F. Monitoring and Evaluation of Transportation Services

Virginia Department of Transportation (VDOT): The Commonwealth Transportation Board provides guidance and oversight for both VDOT and the Department of Rail and Public Transportation (DRPT). The board's 17 members are appointed by the Governor, the Secretary of Transportation is its chair, the Commonwealth Transportation Commissioner is its vice chair, and the DRPT Director is a non-voting member.

Department of Rail and Public Transportation (DRPT): The DRPT Director reports to the Secretary of Transportation and, as indicated above, the Commonwealth Transportation Board provides guidance and oversight for the agency. DRPT works with VDOT and other state agencies to plan and administer a wide range of transportation activities in Virginia and has specific responsibility for oversight, evaluation, and technical assistance for certain federal grant programs, some of which were listed in previous sections of this chapter.

DRPT is also one of the lead agencies in the Commonwealth helping to guide compliance with Presidential Executive Order 13330, described in the introduction to this chapter. In 2003, DRPT took a leadership role in establishing the Interagency Transportation Coordinating Council, now called the **State Agencies Coordinating Transportation (SACT) Work Group**, to promote interagency cooperation at the state level. In its *2010-2012 Strategic Plan*, DRPT describes the role of the SACT Work Group as: "Examination of Virginia's policies, as part of a team of state agencies, to ensure compliance with the U.S. Supreme Court decision called the *Olmstead Decision*. This team is charged with examining all of Virginia's policies affecting persons with disabilities to help them live in the setting that is most appropriate for their needs."

The SACT Work Group was instrumental in development of a *Memorandum of Understanding Related to Coordinated Human Service Transportation in Public and Nonpublic Transit Systems* that was signed by Virginia's Secretary of Transportation and Secretary of Health and Human Resources in June 2007 and is still in effect. In this memorandum of understanding (MOU), the Secretaries agreed to:

- "Continue an Interagency Coordinating Council (SACT Work Group) composed of the state agencies that fund transportation services for elderly and low income individuals and persons with disabilities in Virginia;
- "Develop and implement annual work plans each calendar year to achieve the goals and objectives of this agreement;
- "Produce annual progress reports at the end of each calendar year; and
- "Designate staff to be responsible for administering all aspects of the agreement."

The MOU also requested that the SACT Work Group publish a matrix showing, by state agency, the current service and funding levels for human service transportation as well as any policy constraints that limit coordination of human service transportation across state and local agencies. The work group was also charged with identifying and promoting best practices and

uniform methods to identify system efficiencies and improve the cost effectiveness and coordination of human service transportation. The resulting *2010 State Coordination Model for Human Service Transportation* provided recommendations focusing on state-level and regional structure, the role of Planning District Commissions, ongoing funding structure, the state of Florida as a best practice model, and next steps.

As indicated by the report's name, one of its recommendations called for implementing a transportation coordination model, a regional pilot creating a "state-based Medicaid transportation broker (*e.g.*, a consortium of CSBs—carving out a regional section of the state Medicaid brokerage contract) to specifically test the second level Council-determined recommendations." The second level Council-determined recommendations included development of a uniform client tracking system and uniform cost accounting system, obtaining state-specific scheduling and accounting software, increasing resources to boost coordination efforts, and resolution of Medicaid billing issues involving trips versus units.

Concurrent with these developments, the federal *Safe, Accountable, Flexible, Efficient Transportation Equity Act: A Legacy for Users* (SAFETEA-LU) called for new requirements on grants from the Federal Transit Administration (FTA) administered by DRPT, including creation of coordinated action plans for public transit and human service transportation at the state, regional, and local levels. To be eligible for federal SAFETEA-LU funding in Virginia, an interested entity must demonstrate participation in development of its locality's *Coordinated Human Service Mobility (CHSM) Plan*, which is developed in cooperation with public and private nonprofit human service transportation providers.

To meet these requirements, DRPT held more than 30 workshops in 2007 to assist localities in developing their CHSM Plans. After the workshops, DRPT oversaw the development of the CHSM Plans in 2008. The plans were organized geographically around the existing 21 Planning District Commissions across the Commonwealth. While these CHSM Plans focused on the FTA coordinated planning requirements, they also took a broad view of the mobility issues faced daily by older adults, people with lower incomes, and individuals with disabilities, with the overarching goal of developing a vision for meeting their transportation needs. DRPT continues to work closely with localities as they implement their CHSM Plans.

Public Transportation: Individual operators of local public transportation programs determine how best to monitor and evaluate their performance and quality of service. Virginia does not have a statewide system for coordinating or monitoring their activities. Paratransit services, on the other hand, are now highly regulated and closely monitored for compliance with Federal Transit Administration (FTA) standards. Local providers should be contacted directly for information on their quality assurance practices.

Medicaid-Funded Transportation: The **Department of Medical Assistance Services (DMAS)** is responsible for monitoring the performance of its contracted Medicaid transportation broker. The broker is responsible for receiving and responding to all verbal or written complaints about nonemergency transportation services from service recipients, providers,

DMAS, or other sources. Individuals wishing to report a problem or to ask a question must contact the transportation broker through its toll-free customer service telephone number, 800-742-9758.

The broker is also responsible for monitoring its network of transportation operators to ensure compliance with the terms of their sub-contracts and with all state and federal laws and regulations, including a number of DMAS safety and performance requirements. Operators must meet driver and vehicle requirements, resolve complaints, and deliver courteous, safe, timely, and efficient services.

Specifically, the broker is required to regularly review drivers' licenses, driving records, criminal records, and training requirements of its subcontracted operators. The broker tracks safety equipment carried on vehicles, makes semiannual vehicle inspections, and verifies maintenance records. Operators must provide accident and incident reports to both the transportation broker and DMAS. The safety of service recipients, the assistance provided to them, and driver courtesy are monitored through on-street observations, analysis of complaints, and a semi-annual customer service survey. DMAS staff members and its broker can also conduct unannounced, onsite monitoring of drivers' performance as well as detailed inspections of vehicles. For major safety violations, authorized DMAS employees or the broker may immediately remove any driver or vehicle from service until the deficiencies have been corrected. Deficiencies and corrective actions are documented and become a part of the driver's or a vehicle's permanent record.

In addition to the monitoring activities above, DMAS conducts quality assurance reviews of services. These DMAS **Utilization Reviews** may be conducted anonymously and without advance notice. DMAS is also responsible for conducting fraud investigations in cooperation with state and federal law enforcement agencies.

In 2010, a national research organization, The Center for Research (CFR) in Meridian, Connecticut, conducted a **Client Satisfaction Study** on behalf of Logisticare, the state's current Medicaid transportation broker. Using a random sample generated by Logisticare of Medicaid-funded transportation clients living in Virginia at the time, CFR conducted 404 interviews between October 22 and 26 of that year to determine those clients' level of satisfaction with the transportation services they had received. A random sample of this size has a maximum statistical error of plus or minus five percentage points at the 95 percent level of confidence.

The study report, which is not available online, covered satisfaction with Logisticare's subcontracted transportation operators and their drivers. The interviewed clients rated service on six characteristics: "neat and clean appearance of driver," "driver was courteous," "arriving on time for your appointment," "arriving on time to pick you up for your return trip," "driving safely," and "driving legally." Overall, 89 percent of interview respondents gave the operators and drivers a positive rating in October 2010. This was down from 97 percent in October 2009 and 91.9 percent in May 2009. The lowest percentages of positive ratings from the October 2010 survey were for "arriving on time to pick you up for your return trip" at 80.5 percent (95.8

percent in October 2009) and “arriving on time for your appointment” at 82.3 percent (94.5 percent in October 2009).

The DMAS contract with Logisticare expires on September 30, 2011. Prior to that date, DMAS will issue a Request for Proposals (RFP) for selection of a future contracted Medicaid transportation broker or brokers. Consumer suggestions and comments regarding the RFP can be sent to Transportation@DMAS.virginia.gov. A survey is also being used to collect input from local agencies and associations that serve people with disabilities.

G. Transportation Services Sources Referenced in This Chapter

Links to websites and online documents reflect their Internet addresses in March 2011. Some documents retrieved and utilized do not have a date of publication.

Websites:

American Public Transportation Association:

www.apta.com/resources/statistics/Pages/glossary.aspx

Infinite Potential for Assistive Technology:

www.infinitec.org

National Mobility Equipment Dealers Association (NMEDA):

www.nmeda.org

United We Ride (Federal Inter-agency Coordinating Council on Access and Mobility):

www.unitedweride.gov

Virginia Department of Medical Assistance Services:

www.dmas.virginia.gov

Virginia Department of Rail and Public Transportation:

www.drpt.virginia.gov

Virginia Department of Social Services:

www.dss.virginia.gov

Virginia Department of Transportation:

www.virginiadot.org

WorkWORLD Disability Laws Rights Overview:

www.workworld.org/wwwwebhelp/disability_rights_laws_overview.htm

Documents:

Alder, Leon, and Jones, Joy. (September 2005). *Mobility for All: A Model Approach for the Commonwealth: Best Practices & Expanding Mobility Options for the Transit Dependent*. Final Report to the Virginia Board for People with Disabilities. Four County Transit, Appalachian Agency for Senior Citizens, Cedar Bluff, Virginia. Retrieved from: www.vaboard.org/downloads/gsfourcountyfinalreport.pdf.

Center for Research. (October 2010). *2010 Customer Satisfaction Study-Virginia*. Conducted on behalf of Logisticare. Meridian, Connecticut. Not available online.

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- Virginia Transportation Board. (November 2004) *VTrans2025: A Statewide Multimodal Long-Range Transportation Plan: Phase 3*. Retrieved from: www.virginiadot.org/projects/vtrans/resources/revisedPhase3Reportforctb.pdf.

XI. Emergency Preparedness

A. Introduction

Emergency planning and preparedness are critical for all citizens, and individuals with disabilities often have more complex planning needs. Historically, emergency preparedness planning for persons with disabilities has focused on those residing in congregate settings such as Medicaid waiver homes, state hospitals, training centers and community intermediate care facilities for persons with mental retardation (ICFs-MR), assisted-living facilities, and nursing facilities. In accordance with the *Americans with Disabilities Act* (ADA, 42 USC 12101 *et seq.*) and the U.S. Supreme Court's decision in *Olmstead v. L.C.*, referenced in earlier chapters, increasing attention is now being paid to the needs of individuals with disabilities who live in the community and who may need extra assistance or reasonable accommodations, either to find safe shelter where they are or to evacuate.

The U.S. Department of Homeland Security's **Federal Emergency Management Agency (FEMA)** defines key terms in its National Response Framework (www.fema.gov/emergency/nrf/aboutNRF.htm):

- **Emergency:** "Any incident, whether natural or manmade, that requires responsive action to protect life or property. Under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, an emergency means any occasion or instance for which, in the determination of the President, Federal assistance is needed to supplement State and local efforts and capabilities to save lives and to protect property and public health and safety, or to lessen or avert the threat of a catastrophe in any part of the United States."
- **Emergency Management:** "A subset of incident management, the coordination and integration of all activities necessary to build, sustain, and improve the capability to prepare for, protect against, respond to, recover from, or mitigate against threatened or actual natural disasters, acts of terrorism, or other manmade disasters."
- **Preparedness:** "Actions that involve a combination of planning, resources, training, exercising, and organizing to build, sustain, and improve operational capabilities. Preparedness is the process of identifying the personnel, training, and equipment needed for a wide range of potential incidents, and developing jurisdiction-specific plans for delivering capabilities when needed for an incident."

Since the terrorist attacks of September 11, 2001, emergency management and preparedness have been at the forefront of public awareness. This heightened awareness has caused federal, state, and local governments to examine more regularly their ability to prepare for, respond to, recover from, and mitigate natural and manmade disasters for all citizens. A leader in this area, Virginia is one of 25 states that have received full accreditation by the **Emergency Management Accreditation Program (EMAP)**. Virginia renewed its accreditation in April 2010 by qualifying for expanded standards (increased to 63 from 54 in

2005). EMAP accreditation indicates that an emergency management program meets rigorous national standards for documented compliance in 15 functional areas that include planning and procedures, resource management, training exercises, evaluations and corrective actions, and communications and warning. Although EMAP accreditation is voluntary, it fosters benchmarking and continuous improvement in local and state government emergency management.

Federal efforts are designed to enhance national, state, and local preparedness, and progress has been made at all levels to better prepare for the needs of individuals with disabilities, particularly with respect to sheltering and planning. The 2008 *National Response Framework (NRF)* emphasizes that improving community partnerships strengthens community resilience. It recognizes that better response capabilities are realized when representation by non-governmental organizations (NGOs) and individuals with disabilities in planning is expanded and that better preparation for sheltering and evacuation requires inclusion of NGOs and cooperation across multiple governmental levels.

While some people prefer not to use the term “special needs,” it has a particular meaning to emergency planners. The NRF uses it broadly to refer to:

“Populations whose members may have additional needs before, during, and after an incident in five functional areas, including but not limited to: maintaining independence, communication, transportation, supervision, medical care. Individuals in need of additional response assistance may include those who have disabilities, who live in institutionalized settings, who are elderly, who are children, who are from diverse cultures, who have limited English proficiency or are non-English speaking, or who are transportation disadvantaged.”

In December 2009, two documents published by the U.S. Department of Health and Human Services also emphasized that, where communities are strong at all levels of government and where individuals, families, and the private sector, NGOs, and the academic and research sections are interconnected, their overall health and preparedness for emergency planning and response is stronger. The *National Health Security Strategy of the United States of America* and its companion, the *Interim Implementation Guide for the National Health Security Strategy*, provide the ground work for communities to develop goals and objectives for a more coordinated local, regional, and statewide emergency response strategy. It is anticipated that the full implementation guide will be released soon.

To increase its compliance implementation technical assistance to states, FEMA has established Community Integration Coordinators in each of its regional offices across the country with a central **Office of Disability Integration and Coordination** at its headquarters in Washington, D.C. In June 2010, the office’s director, Marcie Ross, reported to the Subcommittee on Emergency Communications, Preparedness, and Response of the U.S. House of Representatives’ Committee on Homeland Security on the status of general population shelters and the lack of progress for supporting individuals with disabilities. Her remarks noted

that the *Post-Katrina Emergency Management Reform Act* of 2006 (Title VI of PL 109-295) provided a much-needed mandate to integrate the needs of people with disabilities and those with access and functional needs into general emergency management planning, response, and recovery. This statute, enacted to address the shortcomings identified in the preparation for and response to Hurricane Katrina, enhanced FEMA's responsibilities and its autonomy within the Department of Homeland Security. Despite its new requirements to plan for and meet the disaster needs of children and adults with disabilities, the director's review found that many of the same problems were seen during Hurricane Gustav. Individuals were still turned away from shelters, information was inaccessible to persons who were deaf or blind, services required under disability rights laws were not being provided, and catastrophic, but preventable, health impacts were felt by previously stable and independent evacuees with disabilities.

In September 2010, “Getting Real”—**The 2010 Inclusive Emergency Management National Capacity Building Training Conference** in Baltimore, Maryland, called attention to a significant effort at the federal level over the last several years to publish materials supporting inclusive emergency management practices. The conference featured intensive, participatory cross-training and bridge-building activities focusing on three FEMA publications: *Emergency Management Under Title II of the Americans with Disabilities Act (ADA)* and its two addenda, *The ADA and Emergency Shelters: Access for All in Emergencies and Disasters* and *ADA Accessibility Survey Forms and Instructions*. Title II of the ADA requires shelters to provide access to their many benefits, including “safety, food, services, comfort, information, a place to sleep until it is safe to return home, and [the ability] to obtain the support and assistance of family, friends, and neighbors.” Together, these documents serve as a toolkit (www.ada.gov/pcatoolkit/chap7emergencymgmt.htm) that local and state governments can use to facilitate ADA compliance, including a checklist that enables states to monitor compliance and document policies and procedures maintained regarding shelter accessibility.

Virginia has formed an emergency preparedness team within the Health and Human Resources Secretariat, led by the **Virginia Department of Health (VDH)**, with the support of the **Virginia Department of Emergency Management (VDEM)**, agencies that plan or provide services for people with disabilities, and other agencies concerned with the health and wellbeing of all citizens in the event of an emergency. This team has worked to increase awareness and preparedness activities and conducting “gap analyses” of state preparedness efforts on an ongoing basis. It is currently examining ways to improve the involvement of individuals with disabilities in emergency planning and to improve communications and accessibility features of shelters operated by the state and municipalities.

Since the 2008 edition of this assessment, a number of the agencies on this team have taken steps to improve their emergency planning and preparedness, including providing access to related information on their websites and in other forums, and all state agencies are now required to include a goal “to strengthen the culture of preparedness across state agencies, their

employees, and customers” in their state agency strategic plans. Descriptions of some of those efforts appear below.

In its *2010-2012 Strategic Plan* (<http://vaperforms.virginia.gov/agencylevel/src/ViewAgency.cfm?agencycode=702>), the **Virginia Department for the Blind and Vision Impaired (DBVI)** notes that it will be prepared to act in the interests of the citizens of the Commonwealth during and after an emergency, and that its Emergency Coordination Officer will stay in regular communication with VDEM and other Commonwealth Preparedness Working Group agencies

The *2010-2012 Strategic Plan* (<http://vaperforms.virginia.gov/agencylevel/src/ViewAgency.cfm?agencycode=751>) for the **Virginia Department for the Deaf and Hard Hearing (DDHH)** contains specific information on its recent efforts to make the lead agencies responsible for emergency preparedness planning sensitive to the communications needs of its constituents. This includes outreach activities to improve access to information in formats accessible to the hearing impaired.

Consistent with the emergency preparedness goal in its *2010-2012 Strategic Plan* (<http://vaperforms.virginia.gov/agencylevel/src/ViewAgency.cfm?agencycode=262>), the **Department of Rehabilitative Services (DRS)** now conducts an all-hazards Agency Preparedness Assessment to measure compliance with requirements and best practices. The assessment’s components include physical security, continuity of operations, information security, vital records, fire safety, human resources, risk management, and internal controls, as well as the National Incident Management System for Virginia Emergency Response Team (VERT) agencies. As with the other Disability Services Agencies (DSAs) listed in this section, DRS plans to stay in continuous communications with VDEM and other Commonwealth Preparedness Working Group agencies.

In *Across the Continuum—Across the Commonwealth, Virginia’s Four-Year Plan for Aging Services* (www.vda.virginia.gov/pdfdocs/FourYearPlanForAgingServices-RD461-2009.pdf), the **Virginia Department for the Aging (VDA)** acknowledges the importance of emergency planning for seniors, emphasizing “that Virginia ensure that older adults with disabilities are adequately represented in statewide and community-level disaster preparedness planning and testing.” The plan notes VDA’s interest in improving accessibility of shelters and recommends that the state leverage its “No Wrong Door” system (www.vda.virginia.gov/nowrongdoor.asp) to create a statewide emergency response registry through which older adults can consent to identify physical, cognitive, or sensory disabilities that may influence preparedness response and recovery plans. Specific actions to accomplish this, however, have not yet been developed.

Virginia’s **Community Integration Advisory Commission** (www.olmsteadva.com) has also played an important role in interagency coordination and emergency planning for individuals with disabilities in recent years. Commission recommendations were cited in the 2008 edition of this assessment and have influenced planning by state agencies. It is

undetermined, however, at the time of this assessment whether this will continue to be a focus of its work.

The heightened national, state, and local attention on emergency preparedness described in this introduction and further explored in the following sections has been greatly influenced by recent natural disasters and other emergencies that have tested response systems. Additional significant changes, as a result of both past and future events, should be expected, and regular monitoring of the resources listed throughout this chapter and in the reference section at its conclusion is encouraged.

B. Eligibility for Emergency Services

Virginians with and without disabilities and their families are largely responsible for educating themselves about emergency and disaster preparedness, resources, and training in their communities. Local police, fire, and other emergency services, as well as the **Virginia Citizen Corps** (www.vaemergency.com/citcorps/index.cfm) are sources of information and training, typically provided at no cost.

Following a natural disaster or other emergency, victims may be eligible for financial or other assistance from **Disaster Assistance Programs**. Following an emergency declaration by the President of the United States, federally funded assistance is typically distributed through state and local agencies to affected individuals and businesses within specifically designated areas. The federal **Individuals and Households Program** is jointly administered by the **Federal Emergency Management Agency (FEMA)** and the **Virginia Department of Emergency Management (VDEM)**. Additional information appears in this chapter's available services section or can be obtained from these agencies online (www.disasterassistance.gov and www.vaemergency.com, respectively). Applications for assistance can be submitted online or by telephone (800-621-3362 or 800-462-7585 for the speech or hearing impaired). Losses covered by insurance are not eligible for assistance, and submission of an application does not guarantee that assistance will be approved.

C. Access to and Delivery of Emergency Services

Federal, state, and local governments share responsibility for emergency services and preparedness, and this section provides an overview of how those responsibilities are carried out. The draft **National Response Framework**, previously called the *National Response Plan*, describes the key operational components at each level that may be activated when a local emergency occurs.

FEDERAL RESPONSIBILITIES: National leadership in emergency preparedness is provided by the **Department of Homeland Security (DHS)** and the **Federal Emergency Management Agency (FEMA)**. When a disaster strikes, affected states can request and receive assistance from other states through the **Emergency Management Assistance Compact**. This

congressionally ratified organization provides a formal structure to interstate mutual aid, allowing member states to increase their response capabilities by sharing resources.

Following a governor's declaration of a state of emergency and request for federal assistance, federal entities can respond with immediate assistance and subsequent damage assessments during the recovery phase. These entities include the National Response Coordination Center, Regional Response Coordination Centers, and DHS Joint Field Offices and Disaster Recovery Centers. A discussion of their complex responsibilities is beyond the scope of this assessment, and additional information can be obtained online from DHS (www.dhs.gov/files/prepresprecovery.shtm) and FEMA (www.fema.gov/rebuild/index.shtm).

STATE RESPONSIBILITIES: The *Code of Virginia* (44-146.13 through 60) requires interagency cooperation and specifies that the “Governor, the heads of state agencies, and the local directors and governing bodies of the political subdivisions of the Commonwealth are directed to utilize the services, equipment, supplies and facilities of existing departments, offices, and agencies of the Commonwealth and the political subdivisions thereof to the maximum extent practicable consistent with state and local emergency operation plans.”

Through 2010, the Office of Commonwealth Preparedness (OCP) advised the Governor at the cabinet level (VAC 2.2-304 and 305). In this role, OCP served as a liaison between the Governor and the federal Department of Homeland Security (DHS); pursued strategies to secure DHS funding for emergency planning, response, and recovery; and evaluated the outcomes of local, regional, and state agency and private sector efforts in those areas. Other specified duties for OCP included:

- Providing oversight, coordination, and review of all disaster, emergency management, and terrorism management plans for the state and its agencies;
- Serving as the Governor's representative on regional efforts to develop a coordinated security and preparedness strategy;
- Serving as a direct liaison between the Governor and local governments and first responders on issues of emergency prevention, preparedness, response, and recovery; and
- Educating the public on homeland security and overall preparedness issues.

In the spring of 2011, in compliance with House Bill 1773, passed by that year's General Assembly, Governor McDonnell established the new Office of Veterans Affairs and Homeland Security (OVAHS) headed by a cabinet level Secretary to replace the Office of Commonwealth Preparedness. OVAHS is charged to “work with and through others—including federal, state, and local officials, as well as the private sector—to develop a seamless, coordinated security and preparedness strategy and implementation plan. OVAHS also serves as the liaison between the Governor and the federal Department of Homeland Security.” With the creation of this new office, the OCP was eliminated, and at the time of this assessment, Virginia's interoperability efforts were being reorganized. While it appears that OVAHS will maintain key responsibilities related to preparedness, and two of the key initiatives under the OCP, the Secure Virginia Panel

and the State Interoperability Executive Committee, will remain within OVAHS, the actual structure and assignment of responsibilities within key agencies is not yet known. Therefore, since *Code of Virginia* citations, strategic and interoperability plans, and other documents have not yet been changed to reflect this new organizational structure, some references to the OCP remain throughout this chapter with annotations where appropriate.

The **Virginia Department of Emergency Management (VDEM)** is required to provide the Governor, General Assembly, and OVAHS with an annual statewide assessment of the state's progress in preparing for emergencies and, previously, in concert with OCP, has been responsible for managing seven **Regional Preparedness Advisory Committees** focused on "regional initiatives in training, equipment, and strategy to ensure ready access to response teams in times of emergency and facilitate testing and training exercises for emergencies and mass casualty preparedness". Each committee is comprised of representatives from the law enforcement, fire, and health agencies in the jurisdictions covered by one of the seven Virginia State Police regions.

Two additional teams, the **State Interoperability Executive Committee (SIEC)** and the **State Interoperability Advisory Group**, work with the **Commonwealth Interoperability Coordinator's Office**, now within OVAHS, to refine and improve the **Statewide Communication Interoperability Plan (SCIP)**. "Inoperability" occurs when normal operations cease and existing infrastructure becomes ineffectual. Additional information on this plan to ensure "interoperability" of government at all levels when inoperability occurs appears in the monitoring and evaluation section of this chapter.

When the SEIC was codified in 2008, its membership was expanded and now includes the Secretaries of Public Safety and Technology and representatives from VDEM, the Virginia Office of Emergency Medical Services, and the Departments of Transportation, Military Affairs, and Criminal Justice Services, as well as representatives from the Virginia Association of Governmental Emergency Medical Services Administrators, Statewide Agencies Radio System, Virginia Emergency Managers Association; Virginia Professional Fire Fighters, Virginia State Firefighter's Association, and one member of each of the seven Regional Preparedness Advisory Committees. The SIEC's primary responsibilities are to approve changes in direction of Virginia's strategy, coordinate protocols with the Coordinator of Interoperability, make formal recommendations to the Commonwealth Preparedness Working Group and the Secure Commonwealth Panel concerning DHS interoperability grant funds, and develop minimum requirement recommendations for interoperability communications.

The Benchmarking and Accountability Office within Commonwealth Interoperability Coordinator's Office has the important function of ensuring establishment of the statewide interoperability plan and coordinating other major interoperability plans across the Commonwealth. As part of these efforts, the **Virginia Interoperability Picture for Emergency Response (VIPER)** was developed and is being implemented for use by emergency managers and first responders. VIPER provides an interactive, GIS-based common operating tool that enhances both planning and response capabilities. It is part of an ongoing data interoperability

effort supported by the SIEC and implemented by VDEM in concert with other state and local agencies. VIPER is a part of the DHS-sponsored VirtualUSA project and has been nationally recognized.

All Virginia executive branch agencies have statutory and regulatory authority to plan for emergencies, and certain cooperative strategies are authorized should populations need to evacuate, relocate, and cooperate to improve the likelihood of human and animal survival. Services provided by the Virginia Departments of Emergency Management (VDEM), Social Services (DSS), Health (VDH), and Behavioral Health and Developmental Services (DBHDS) are of primary interest to persons with disabilities. In fulfilling their responsibilities, DSS and VDH collaborate closely with local social services and health departments, respectively. Other state agencies involved in evacuations include the Departments of Housing and Community Development (DHCD), Agriculture and Consumer Services (VDACS), and Transportation (VDOT).

Virginia Department of Emergency Management (VDEM): In its capacity as the designated lead state agency for emergency planning and response, VDEM's September 2009 *Commonwealth of Virginia Emergency Operations Plan (COVEOP)* provides localities with information on state requirements and support related to their emergency preparedness and response activities. Localities are advised to have a shelter plan as a part of their emergency operations plan (EOP) and are directed to initiate those functions necessary to protect life and property in accordance with that plan. They are directed to provide relevant information to the state in the event that state-managed shelters need to be opened, and they are further advised, but not mandated, to identify their populations with special needs.

COVEOP also outlines protocols to be followed by other state agencies in coordination with local agencies and organizations. Those agencies include, but are not limited to the Departments of Social Services (DSS), Behavioral Health and Developmental Services (DBHDS), Agriculture and Consumer Services (VDACS), Education (VDOE), Military Affairs (DMA), Corrections (VADOC), and General Services (DGS). Appropriate communications devices to ensure that people with disabilities are properly accommodated to understand the circumstances of the emergency are included in COVEOP as well.

During both normal and emergency operations, VDEM's field coordinators maintain a dialog between VDEM and the localities in their assigned regions to ensure that state and federal programs support and enhance the development of comprehensive local emergency management capabilities. VDEM also synchronizes capabilities and threat assessments, conducts state planning, and coordinates federal funding and incident management activities between state agencies and localities. When major emergencies or disasters do affect communities, the regional coordinators provide critical coordination of information and resources for those communities to alleviate problems and promote a return to normalcy.

Specifics of VDEM program are covered in the next section of this chapter and in greater detail on its website (www.vaemergency.com). Since the 2008 edition of this assessment, its

emergency preparedness documents have expanded their content to note the important role that state agencies serving individuals with disabilities have in emergency preparedness, including the Departments for the Deaf and Hard of Hearing (DDHH), Blind and Vision Impaired (DBVI), and Aging (VDA), and the Departments of Behavioral Health and Developmental Services (DBHDS), Rehabilitative Services (DRS), and Housing and Community Development (DHCD). These materials emphasize the universal need for access to supports during and after an emergency with specific references to individuals who are deafblind, use a wheelchair or service animal, do not speak English, or have other needs for additional assistance.

Virginia Department of Social Services (DSS): The 2009 COVEOP identifies DSS as the lead agency for **Emergency Support Function (ESF) 6: Mass Care, Emergency Assistance, and Housing and Human Services**. ESF 6 addressed the need for shelter and other human needs, including the needs of vulnerable populations, and numerous state agencies and volunteer organizations provide support to DSS in this effort. Local governments are encouraged to partner with volunteer groups for emergency augmentation as well. COVEOP recommends that local departments of social services establish a memorandum of understanding between the jurisdiction and its American Red Cross chapters to ensure that mass feeding, overnight sleeping accommodations, back-up power, augmented communication including radio backup, a medical aid station, security, traffic control, and fire inspections are provided at shelter operations.

DSS is also responsible for oversight of the **State-Managed Shelter (SMS) Program**. This program is administered and operated by the state to support mass evacuations across jurisdictional boundaries, when ordered by the Governor. SMS facilities are opened only in response to catastrophic events, and when appropriate, messages regarding those sites are communicated by various media to the public. They are designed to keep family units together by providing rapid registration, tracking, and reunification of individuals and families and by collocating persons with special medical needs, who are elderly, or have disabilities within general population shelters. If SMS sites are activated, ESF 6 assumes that localities will have an understanding of local special needs populations and be able to make this information available to the state when requested. DSS is then responsible for tracking the movement of individuals into and out of shelter services and reporting the details to the Virginia Emergency Operations Center operated by VDEM, which carries the ultimate responsibility for the receipt of this information.

SMS sites have been identified at 19 locations across the Commonwealth. Most are on campuses of public institutions of higher education; however, a few are on private nonprofit properties. Sites are assessed by a multi-disciplinary team with representatives from the SMS facility itself, local government, State Police, DSS, VDH, DRS, VDACS, and the Red Cross. DRS assesses the site for compliance with the *Americans with Disabilities Act (ADA)*, and those areas needing modification are addressed as funding is available. VDACS acts as the lead agency for sheltering pets in an emergency, and in response to occurrences during Hurricane Katrina and other events, local and state plans are being developed to shelter pets and service animals in proximity to their owners.

DSS is also responsible for ensuring compliance with rules and regulations for the operation of assisted-living facilities (ALFs) that house the elderly or persons with disabilities. *Virginia Emergency Preparedness and Response Plan* regulations (22 VAC 40-72-930, <http://leg1.state.va.us/cgi-bin/legp504.exe?000+reg+22VAC40-72-930>) describe compliance standards are detailed further in the monitoring and evaluation section of this chapter. Licensed adult daycare centers, children's residential facilities, and child day centers must meet regulatory requirements for emergency response planning as well.

Virginia Department of Health (VDH): The *Code of Virginia* (32.1-19) establishes the duties the Commissioner of Health's responsibilities, in cooperation with state, regional, and local partners, for coordinating the Commonwealth's preparedness and response efforts with respect to bioterrorism, infectious disease outbreaks, and other public health emergencies. VDH consults with fire departments, ambulance services, paramedics, and other local emergency service providers and offers them training and technical assistance that enables them to better prepare to provide the highest quality emergency medical care to those in need in the event of a health emergency. It has also developed emergency preparation and response guidelines for adult daycare centers, assisted-living facilities, and other services licensed by DSS.

The long-standing VDH **Office of Emergency Medical Services (OEMS)** has the mission "to reduce death and disability resulting from sudden or serious injury and illness in the Commonwealth through planning and development of a comprehensive, coordinated statewide emergency medical services system and provision of other technical assistance and support to enable the EMS community to provide the highest quality emergency medical care possible to those in need."

In fall 2010, VDH restructured its emergency preparedness functions, establishing the new **Office of Emergency Preparedness (OEP)** and **Office of Risk Communications and Education (ORCE)**. OEP regional teams coordinate with federal, state, and local partners to prepare for and respond to chemical, biological, radiological, nuclear, explosion, and natural disasters, infectious disease outbreaks, and other emergencies requiring rapid reaction. Team members include experts in hospital preparedness, continuity of operations, and medical countermeasures, a physician consultant, an industrial hygienist, planners, exercise coordinators, and volunteers. ORCE public information officers and educational trainers engage in emergency preparedness and response training and communications, using distance learning, events, and other outreach tools.

Virginia Department of Health Professions (DHP): With the mission to "ensure safe and competent patient care by licensing health professionals, enforcing standards of practice, and providing information to health care practitioners and the public," DHP's role in emergency preparedness is largely in support of VDH, VDEM, and other lead agencies. State statute provides that its Director, in consultation with those agencies, may adopt regulations requiring health professionals to report to specified authorities in the event of a public health or animal health emergency. In addition, VDH's *2010-2012 Strategic Plan* notes that it has developed an enhanced "electronic content management" system consistent with *Code of Virginia*

requirements (54.1-2506.1) for the collection and use of emergency contact information, which has improved its ability to provide information on specified health professionals and strengthen preparedness across state agencies, their employees, and customers. Professions required to submit information to the system and other details about it are available from DHP online (www.dhp.virginia.gov) along with links to state emergency preparedness websites including the Ready Virginia site described later in this chapter.

Virginia Department of Behavioral Health and Developmental Services (DBHDS): With respect to emergency preparedness, DBHDS is responsible for ensuring that the mental health and intellectual disability residential facilities that it operates and the public and private services that it licenses and oversees comply with all relevant state and federal laws, regulations, and policies. Information on those facilities and services can be found in the Community Supports and Institutional Services chapters of this assessment.

DBHDS Policy 1043(SYS) 08-1: *Disaster and Terrorism Preparedness* requires that: “The Department, state facilities, and CSBs shall, to the greatest extent possible, assure that emergency preparedness, response, recovery, and post disaster planning undertaken by state agencies, local governments, and other organizations integrate mental health into physical health and medical support functions” (www.dbhds.virginia.gov/documents/Adm/adm-SBPolicies1043.pdf). The policy manual covers specific action steps for educating policy makers, establishing liaisons between service staff, ensuring participation in state and local emergency services planning, and advocating for more funding and human resources to respond to and recover from emergencies.

LOCAL RESPONSIBILITIES: The *Code of Virginia* (44-146.19) states that: “Each political subdivision within the Commonwealth shall be within the jurisdiction of and served by the Department of Emergency Management and be responsible for local disaster mitigation, preparedness, response and recovery.” As such, each political subdivision is required to maintain an agency of emergency management, consistent with requirements of state disaster plans, that has jurisdiction over that political subdivision. The agency’s powers and duties include, but are not limited to, appointment of a director and coordinator of emergency management, establishment of a local emergency preparedness office, and distribution of food, fuel, clothing, goods, and services within the boundaries of that political subdivision. To do so in times of emergency, according to information provided by VDEM, localities may proceed without regard to time-consuming procedures and formalities prescribed by law (except mandatory constitutional requirements) related to performance of public works, entering into contracts, incurring obligations, employing temporary workers, renting equipment, purchasing supplies and materials, levying taxes, and appropriating and expending public funds.

Local jurisdictions are further required to maintain an emergency operations plan (EOP) that they must comprehensively review and update every four years. As part of its technical assistance, VDEM provides localities with an EOP template, which is currently under review to fully incorporate special needs considerations. As described elsewhere in this chapter, there are

also regulations and guidelines for local oversight of emergency planning for residents of congregate facilities such as nursing homes, assisted-living facilities, and adult daycare centers.

Political subdivisions also have the authority to enter into mutual aid agreements with other jurisdictions, inside or outside the state, and with private firms for reciprocal assistance when a disaster exceeds local capabilities. The **Virginia Statewide Mutual Aid (SMA)** program provides a formal structure for these arrangements. SMA “member” localities impacted by an event can request and receive assistance and resources from other members, increasing their capability to respond to that event.

Planning processes vary by locality, and an analysis of each local planning process is beyond the scope of this assessment. For more information, localities themselves as well as the agencies and organizations described in this chapter should be consulted directly. In localities where they exist, Centers for Independent Living (CILs) are also a good starting point for individuals with disabilities to become involved in emergency planning and learn more about what to expect in an emergency and afterward. Other useful agencies include local health departments, Community Services Boards (CSBs), Area Agencies on Aging (AAAs), and faith-based organizations. The Community Supports chapter contains detailed information on CILs and AAAs.

D. Available Emergency Preparedness Programs and Services

An all-inclusive description of the varied and ever-changing programs offered at the local level are beyond the scope of this assessment. Descriptions of major, state-wide efforts appear below. Individuals are encouraged to contact their local departments of social services and health or Red Cross chapters to find out more about emergency preparedness and disaster relief programs in their communities.

Virginia Department of Social Services (DSS): Once the Governor has requested and the President has approved a federal disaster declaration for Virginia, DSS and the Federal Emergency Management Agency (FEMA) jointly administer the **Individuals and Households Program (IHP)**. IHP’s two components, **Housing Assistance** and **Other Needs Assistance**, can be used by individuals and households within the disaster area for necessary disaster-related expenses and serious needs that cannot be met through other means. IHP funds are not intended to cover disaster losses or to purchase items or services that may be considered nonessential, luxury, decorative, or improvements. The current maximum for all forms of assistance under IHP is \$30,100.

FEMA Housing Assistance is 100 percent federally funded and is available to applicants displaced from their primary residences. It can be used to cover the cost of temporary housing or for permanent housing construction, repair, or replacement in situations where pre-disaster housing has been deemed uninhabitable and no insurance is available to cover those expenses.

Federal funds cover 75 percent of Other Needs Assistance, matched by 25 percent from the state and is most commonly used by eligible individuals to cover loss of essential and necessary personal property. It can also help meet expenses for medical and dental services, funerals, and transportation. Other potentially covered expenses include moving and storage, group flood insurance, and miscellaneous post-incident expenses.

In addition to the IHP financial grants above, DSS may also administer the **Supplemental Nutrition Assistance Program** in response to some disasters, and the Virginia Employment Commission (VEC) may offer **Disaster Unemployment Assistance**. A **Crisis Counseling** grant program may administered by the Department of Behavioral Health and Developmental Services (DBHDS), and the Young Lawyer's sections of both the Virginia State Bar Association and Virginia chapter of the American Bar Association may provide limited free legal services.

Virginia Department of Emergency Management (VDEM): To help ensure that the Commonwealth is prepared for a disaster and to coordinate and administer disaster relief programs, VDEM works with the Federal Emergency Management Agency (FEMA) to develop and maintain state emergency plans. These state-level plans serve as blueprints for response to a variety of scenarios and assist communities in designing effective, long-range mitigation and emergency operations plans addressing hazards specific to their communities. When emergencies occur, VDEM coordinates state and local response efforts with federal agencies and updates the Governor on existing conditions. Resources and programs offered by VDEM and its collaborators include:

- Training exercises and drills across the Commonwealth in emergency management, search and rescue, and hazardous materials response to provide local responders with opportunities to practice those skills in controlled settings so that they can more effectively deal with disasters and their aftermath.
- Intensive annual public awareness campaigns, in conjunction with the National Weather Service and local emergency managers, to promote tornado, hurricane, and winter weather safety.
- **Ready Virginia** (www.readyvirginia.gov) and other online resources with emergency preparedness information on how to prepare a personal plan, create a disaster supply kit, and stay informed, as well as specialized content for older residents, individuals with disabilities, and pet owners.
- A tool-kit for small business emergency preparation, available at www.vaemergency.com, which provides specific guidance regarding employees with disabilities and recommends including them in the development of emergency plans to ensure accommodation of vision, hearing, cognitive, and mobility impairments.

The Community Emergency Response Teams (CERT) program, adopted by VDEM as a best practice in 2004, continues to expand. These teams receive special training to enhance their ability to recognize, respond to, and recover from a major emergency or disaster. The program is

available through community agencies designated by local governments and typically involves fire, police, health officials, and other emergency responders; local programs such as those described below in which VDEM is involved to varying degrees; and other government agencies and community partners. Citizens can contact their local government to learn where training is provided and how to become involved. Statewide, as of 2010, there were approximately 50 local emergency management teams, and 5,800 Virginians have been trained through the CERT program.

The **Medical Reserve Corps (MRC)** prepares health professionals, volunteers, and other individuals to respond to health-related emergencies. It is comprised of physicians, registered nurses, certified nursing assistants, and others with education and training in a medical field who have registered to assist in an emergency, and like CERT, it is locally based.

Neighborhood Watch programs, sponsored by the National Sheriff's Association and its local affiliates, have been bringing citizens, law enforcement, and local officials together successfully to protect their communities for 30 years. An estimated 316,404 households and 803,666 individual volunteers, 12 percent of Virginia's population, participate in 4,794 Neighborhood Watch programs involving more than 187 law enforcement agencies representing 119 entities across the Commonwealth. Although Neighborhood Watch originated as a crime prevention program, VDEM interfaces with it and the Virginia Crime Prevention Association to build community capacity and provides CERT training to its participants.

Volunteers in Public Service (VIPS) is another program operated by local law enforcement officials across Virginia involved with the CERT program. In a 2010 presentation, VDEM noted that 1,777 VIPS participants in 48 programs have contributed 246,221 hours of service to Virginia law enforcement since 2002, at an estimated value of \$5,281,440.45 (based on Virginia's hourly rate of \$21.45 for the value of volunteer service).

Virginia Voluntary Organizations Active in Disasters (VA VOAD) is a collaboration of faith-based and nonprofit organizations formed to enhance and support the response of nongovernmental agencies to emergency events in the Commonwealth (<http://vavoad.org/about-va-voad.htm>). It works to improve communications between its participants, the state's Emergency Operations Center, VDEM, and FEMA to better coordinate and manage their assets and resources.

There are also 36 active registered **Fire Corps** programs in Virginia, according to the **Virginia Department of Fire Programs**. The Fire Corps program is a partnership of the International Association of Fire Chiefs' Volunteer and Combination Officers Section, the International Association of Fire Fighters, and the national Volunteer Fire Council, and its National Advisory Committee includes representatives from nearly every national fire services organization. The program's main goal is to provide non-operational support for resource-constrained volunteer, professional, and combination fire departments through community volunteerism, allowing them to dedicate more of their time to their core mission of preparing for and responding to emergencies. Some examples of this volunteer, non-operational support

include marketing, placement of smoke alarms in homes, child safety checks, and administrative assistance. Fire Corps activities complement those of the programs described above.

Virginia Department of Health (VDH): The VDH Office of Emergency Preparedness provides a variety of resources to assist with emergency planning and response. The **Disaster Supply Kit Checklist**, developed in collaboration with VDEM and the American Red Cross, describes items to have on hand to ensure that adequate sanitation supplies, clothing, bedding, first-aid items, food, and survival tools are set aside and rotated on an ongoing basis. VDH's **Pandemic Flu Resources** include checklists for individual and family planning as well as information on medical conditions needing particular attention during pandemic flu, bioterrorism planning and response, and related websites for additional resources. VDH's emergency preparedness and response website (www.vdh.virginia.gov/EPR/) links to social networking sites, pod casts, and sources of recently developed and updated information on specific events, materials for teaching and working with children, hazard-specific learning modules for terrorism, and hurricane and tornado planning materials. Specific information for individuals with disabilities and their families regarding emergency preparation and response, including sheltering in place, have been posted online by VDH, along with links to resources maintained by VDEM related to special needs supports.

Virginia Department of Behavioral Health and Developmental Services (DBHDS): Contact information listings for **Disaster Coordinators** at local Community Services Boards (CSBs), links to emergency preparedness information by FEMA, VDEM, and VDH, and a variety of other related resources for people with disabilities, their families, and professionals can be found on the DBHDS website (www.dbhds.virginia.gov). In particular, the **Public Information and Education Template for Disaster Mental Health** (www.dbhds.virginia.gov/CWD-default.htm), developed by DBHDS in 2005, can be used as a training guide by individuals working in behavioral health and developmental services and contains sample documents for many different scenarios that be duplicated for use in home, workplace, or community emergency planning and disaster response.

DBHDS publications increasingly focus on public education related to preparing for emergencies and target senior citizens, children, teenagers, and others who have special needs during and following an emergency. Other resources available online from DBHDS, some of which are listed below, include guides for caregivers, how to deal with crises and grief, and tips for coping with potential behavioral reactions to emergencies.

- *Helping to Heal* (www.dbhds.virginia.gov/CWD-HelpingToHeal.htm):
 - *A Training on Mental Health Response to Terrorism*
 - *Behavioral Health for Public Health Emergencies*
 - *Behavioral Health Planning and Response to Natural Disasters*
 - *Family Preparedness Kit*
 - *Family Emergency Preparedness Plan*

- *The Community Resilience Project* (www.dbhds.virginia.gov/OMH-DeafCommunityResilienceProject.htm)
- *Tips for Teachers* and *Tips for Students* (www.dbhds.virginia.gov/CWD-EducationTemplate.htm)

Virginia Department of Fire Programs (VDFP): In addition to the Fire Corps program previously described, VDFP provides training and technical support, including approximately 50 accredited and non-accredited fire training programs that are updated every five years. Through partnerships with 23 institutions of higher education, 22 of these training programs are eligible for college credit. Information on other important emergency planning and response projects, such as the **Virginia Dry Hydrant Grant Program, Get Alarmed, Virginia**, and the **Burn Building Grant Program**, is available online (www.vafire.com) and in the department's *2010 Annual Report*, also available on its website.

E. Cost and Payment for Emergency Preparedness

Virginia Office of Veterans Affairs and Homeland Security (OVAHS): This new cabinet-level office's revised website provides a link to the following expenditures for its predecessor, the **Office of Community Preparedness (OCP)**, for state fiscal years (SFY) 2005 through 2010.

OFFICE OF COMMUNITY PREPAREDNESS EXPENDITURES

<u>State Fiscal Year</u>	<u>Expenditures</u>
2005	\$765,926
2006	842,415
2007	1,003,795
2008	1,116,105
2009	977,955
2010	\$963,949

Source: Commonwealth Data Point.

A strategic plan and base budget for OVAHS for the next biennium were not yet available at the time of this assessment; however, according to OCP's 2010-2012 Strategic Plan, which is still posted to the Virginia Performs website, its base budget for both SFY 2011 and 2012 included \$1,033,299 in state General Funds and \$65,000 in other funds.

Virginia Department of Emergency Management (VDEM): According to the agency's 2010-2012 Strategic Plan, 79 percent of its budget comes from federal sources. The remainder consists of state General Funds (12 percent), Commonwealth transportation dollars (2 percent), funding from Dominion Power for state and local government radiological emergency preparedness (6 percent), and other sources (one percent) such as support for hazardous materials disaster responses and related training for fire programs that comes from billings for "hazmat" responses. VDEM funding of \$87,258,571 for the 2010-2012 biennium was a reduction of less

than one percent from \$87,969,780 received in 2008-2010 and a reduction of more than five percent from \$92,587,440 received in 2006-2008. To accommodate these reductions, the agency reduced the frequency of some training programs, decreased travel costs, and eliminated non-crucial positions.

The Office of Veterans Affairs and Homeland Security (OVAHS) works in coordination with the VDEM to administer preparedness grant funding to Virginia localities and state agencies. These grants, released annually by the U.S. Department of Homeland Security (DHS) through the **Homeland Security Grant Program (HSGP)**, are used to enhance state and local capabilities in law enforcement, critical infrastructure protection, statewide sheltering, incident management, and anti-terrorism training. Improvements to chemical, biological, radiological, nuclear, explosive, and other hazmat capabilities, homeland security exercises, and an evaluation program are also supported, along with citizen and community preparedness, interoperable communications, information sharing, and health and medical readiness. Once DHS has released its annual grant guidance, regional meetings are held to explain the competitive process, any changes in the federal guidelines, and the preferred focus of project plans with respect to federal and state strategic goals and objectives.

Virginia received awards through four DHS grant programs in 2010. Its **State Homeland Security Program (SHSP)** received \$18 million, and \$282,000 was received to support Virginia's **Citizen Corps** program. Two **Urban Areas Security Initiative (UASI)** grants were received in the amounts of \$7.3 million for Hampton Roads and \$2.6 million for central Virginia. The National Capital Region, which includes Northern Virginia as well as the District of Columbia and parts of Maryland, received \$1.9 million to support a **Metropolitan Medical Response System (MMRS)**.

Virginia Department of Social Services (DSS): As noted earlier in this chapter, DSS is responsible for determining eligibility for disaster relief under the **Individuals and Households Program (IHP)**. This funding, 75 percent federal plus 25 percent required state match, becomes available when a disaster occurs and varies with the severity of the event. There is no cap on its total amount; however, as also noted previously, there is a maximum possible award per household.

Virginia Department of Health (VDH): Funding is received from multiple federal sources, including the U.S. Centers for Disease Control (CDC), Health Resources Services Administration (HRSA), and Department of Homeland Security (DHS) to support VDH disaster and emergency preparedness efforts. The VDH 2010-2012 *Strategic Plan* reports that its health care emergency preparedness and response activities are 100 percent federally funded through two separate but interrelated cooperative agreements with the CDC and the Office of the Assistant Secretary for Preparedness and Response (ASPR) of the U.S. Department of Health and Human Services. VDH received \$25,437,696 in core funding from CDC and ASPR, plus one-time special funding for H1N1 influenza response activities. In total, \$34,958,274 was received to support state, regional, and local public health jurisdictions' preparations, including

collaborations with hospitals and other health care systems, to respond to disasters, bioterrorism, and other public health emergencies.

The strategic plan also notes that federal funding has remained level or decreased and that it may be subject to changing requirements under the newly formulated National Health Security Strategy. These factors may impede service delivery and VDH's ability to respond to future emergencies.

F. Monitoring and Evaluation of Emergency Preparedness

Office of Veterans Affairs and Homeland Security (OVAHS): As noted earlier in this chapter, OVAHS, which replaced the **Office of Commonwealth Preparedness (OCP)**, now serves as the liaison between the Governor and **U.S. Department of Homeland Security (DHS)** and oversees, coordinates, and reviews all disaster, emergency, and terrorism management plans for the state, its agencies, and its political subdivisions. Its work is performed through the **Secure Commonwealth Panel** and its subpanels, the **Commonwealth Preparedness Working Group** and the **Regional Preparedness Advisory Committees**. The Virginia Military Advisory Council and the Virginia Commission on Military and National Security Facilities, which provide oversight and policy guidance on related matters, are also now part of OVAHS.

Several years ago, the DHS charged each state with developing a list of its critical infrastructure and key resources. In response, OCP worked with the Virginia Department of Transportation (VDOT), the Virginia State Police, and other federal, state, local, and private partners to identify, assess, and prioritize Virginia's critical infrastructure and develop plans to protect it.

Complementing this effort, OCP helped to create and implement Governor Tim Kaine's *Executive Order 44* directing all executive branch agencies to prepare or update their emergency response plans. Those **continuity of operations (COOP) plans** address how critical operations will be maintained and the security of customers and employees will be ensured in the event of a disaster or other emergency. The order further directed that COOP plans be submitted to OCP yearly and be part of annual preparedness assessments. COOP plans follow a template designed by the **Virginia Department of Emergency Management (VDEM)** that has been noted as a best practice, and OCP's 2010-2012 *Strategic Plan* reports that Virginia has been recognized nationally as a leader in preparedness planning and that DHS touts its **Statewide Communications Interoperability Plan (SCIP)** as a national model. The strategic plan also notes that the state has made significant progress in preparedness for hurricanes and an influenza pandemic.

The SCIP, mentioned briefly in the access and delivery section, is developed annually by the **Commonwealth Interoperability Coordinator's Office (CICO)** and the **Virginia State Interoperability Executive Committee (SIEC)**, now under OVAHS. It does not specifically reference individuals with disabilities, but as a part of evaluating where the Commonwealth

stands, it assesses municipal, regional, and statewide progress in interoperability planning. The SCIP vision is stated as follows:

“By 2015, agencies and their representatives at the local, regional, state, and federal levels will be able to communicate using compatible systems, in real time, across disciplines and jurisdictions, to respond more effectively during day-to-day operations and major emergency situations.”

The latest version of SCIP, released by CICO in January 2010, lists accomplishments for 2009 and details the distribution of funds, exercises undertaken, and successfully implemented practices. Many of the activities listed indicate improvements in collateral communications systems. For example, the state has been complimented on building upon the **Commonwealth’s Link to Interoperable Communications (COMLINC)** in several regions. COMLINC connects jurisdictions with one another and with the **Virginia State Police Statewide Agency Radio System (STARS)**.

The January 2010 SCIP also mentions development and release of a 2009 baseline survey of municipal governments to assess the state’s true interoperable communications capabilities. The plan states that “the survey will catalog communications equipment, and measure the state’s level of interoperability against the SAFECOM Interoperability Continuum”; however, it does not provide any details about the survey’s contents, the data collected, or specific findings. Without this information, an assessment of the survey’s outcome is not possible.

Earlier, under “Local Responsibilities” in the access and delivery section, it was pointed out that Virginia law requires political subdivisions to maintain their own local emergency management agencies. Their plans must be consistent with state plans, including SCIP, and they are empowered to review and suggest amendments to the emergency plans of nursing homes, assisted-living facilities, adult daycare centers, and child daycare centers within their jurisdiction. Obtaining and assessing these reviews is beyond the scope of this document.

Virginia Department of Emergency Management (VDEM): Each year, the *Code of Virginia* (44-146.18) requires VDEM to submit an executive summary and report on the status of local emergency operations planning to the Governor and General Assembly. VDEM is also required by statute (2.2-305) to conduct an annual statewide assessment of both public and private entities vital to emergency response planning that includes an examination of equipment, personnel, training, response times, and other factors.

To meet these requirements, VDEM has administered a self-assessment survey of local emergency preparedness programs each year since 2003, using a uniform format referred to as the **Local Capability Assessment of Readiness (LCAR)**. This survey has been refined each year and is used to assess local funding needs. It contains questions regarding individuals with disabilities and how municipalities address issues related to special needs populations as well as animal care and control. Detailed information gathered through the survey is confidential;

however, information that is available indicates that the status of local municipal emergency preparedness response and recovery activities varies widely.

VDEM works with local emergency planners to help them draft and improve their local **Emergency Operations Plans (EOPs)**, and a plan is deemed to be “current” when the governing body of the jurisdiction that it covers comprehensively reviews and adopts it every four years. At the close of 2010, VDEM noted that 109 of 139 Virginia jurisdictions (78 percent) had local EOPs that were current. This was a slight increase from 2007, when 107 plans were current, due to the adoption of plans by some localities while plans lapsed or were still under review for others. Some jurisdictions across the state have small emergency management staffs and do not have the ability to focus efforts on plan development, even when VDEM supports their efforts through training and other resources.

Each year, VDEM conducts the **Virginia Emergency Response Team Exercise (VERTEX)** to assess the Commonwealth’s response to emergencies. Exercise scenarios change from year to year, but always include a significant power outage. Disability services agencies are included as exercise participants and evaluators to provide feedback and make recommendations for improvement, including how to better communicate with individuals with disabilities and involve them in exercise planning and as exercise participants.

Virginia Department of Health (VDH): The **VDH Office of Licensure and Certification (OLC)** administers licensing programs for hospitals, outpatient surgical hospitals, nursing facilities, home care organizations, and hospice programs. To be licensed, each type of facility must comply with specific state regulations, including those regarding emergency preparedness.

Each licensed nursing facility is required to have a written plan for the protection and possible evacuation of its residents during disasters and other emergencies (12 VAC 5-371-190), and their residents must be protected to the extent possible by proper implementation of those plans. VDH guidelines that address evacuation planning, how to harden a facility, and a year-round disaster planning time line are available online to assist with the development of facility-specific emergency preparations.

From September through October 2009, VDH held **Emergency Planning for Congregate Care Facilities** sessions in Abingdon, Roanoke, Bridgewater, Fredericksburg, Norfolk, Newport News, Petersburg, Richmond, and Fairfax. Over 1,100 staff and management attendees represented 450 assisted-living, adult and children’s residential, child daycare, correctional, and other group-care facilities. Sessions covered:

- Discussion of influenza, norovirus, and other common communicable disease threats in congregate care settings and methods of prevention;
- The planning process, including what to include in the plan, how to identify threats, and continuity of operations during a crisis;
- Effective communications with clients, staff, and families during a time of crisis; and

- A hands-on exercise using a planning template to write an emergency response plan.

Federal grant processes covering VDH emergency preparedness activities are rigorous and performance-based, and following all emergency drills or exercises and actual emergency responses, VDH publishes After Action Reports and Improvement Plans. VDH also participates in several national emergency preparedness certification or recognition programs, including:

- The **Read or Not Report (Protecting the Public's Health from Disease, Disasters, and Bioterrorism)** by the Trust for America's Health, featuring state-by-state health preparedness scores based on annually changing key readiness indicators.
- **Project Public Health Ready** by the National Association of County and City Health Officials, a competency-based training and recognition program that assesses preparedness and assists local health departments or groups of local health departments working collaboratively as a region in responding to emergencies. All of Virginia's local health districts are participating or have participated in this process, and VDH will be initiating a similar state-based process with the Association of State and Territorial Health Officials within the year.
- The **State and Local Strategic National Stockpile Technical Assistance Review** by the U.S. Centers for Disease Control (CDC), an annual review of VDH and local capabilities and capacities to implement Medical Countermeasure Distribution and Dispensing Plans.

Virginia Department of Behavioral Health and Developmental Services (DBHDS) and Virginia Department of Social Services (DSS): Both agencies have regulations which address emergency preparedness and response requirements for all the service providers that they license. While DSS regulations (22 VAC 40) are more detailed and specific to individual types of facilities and services than those for DBHDS (12 VAC 35), the key provisions of both are consistent and their core language regarding emergency preparedness and planning is nearly identical. Key provisions for providers of DSS and DBHDS licensed services are listed below as part of this brief discussion of their separate, but similar, activities related to oversight and training.

DBHDS licenses providers of services such as community intermediate care facilities for persons with mental retardation (ICFs/MR), group homes, and other residential programs for persons with intellectual disabilities, mental illness, or substance abuse disorders. Links to licensing requirements related to emergency preparedness for non-children's residential facilities can be found at www.dbhds.virginia.gov/OL-Application.htm#Regulations. Legislation passed by the 2008 General Assembly amended the *Code of Virginia* to authorize the DBHDS Office of Licensing as the sole agency responsible for licensing residential programs that provide treatment or services onsite for children and adolescents who have an emotional disturbance, intellectual disability, substance abuse disorder, or brain injury. New regulations reflecting this statutory change went into effect on January 1, 2009, and can be found at www.dbhds.virginia.gov/OL-ApplicationChild.htm. Previously, these facilities were governed both by the *Standards of Interdepartmental Regulation of Children's Residential Facilities*

issued on December 28, 2007, and the DHBDS *Regulations for Providers of Mental Health, Mental Retardation, and Residential Services for Children*.

As noted in previous sections of this chapter, DSS licenses assisted-living facilities, adult and child daycare centers, and a variety of other residential and non-residential service providers. DSS is also responsible for oversight of the State-Managed Shelter (SMS) Program. For the details of its licensing requirements, visit its homepage at www.dss.virginia.gov, then use its search engine or menus to find information on the specific type of facility or service.

Service providers licensed by both DSS and DBHDS are required to assess the various risks that would disrupt the normal course of their operations and must ensure that they have undertaken emergency preparedness and response planning. Regulations cover requirements for review, revision, and communication of their plans, related training, reporting of emergencies, and actions that must be taken to ensure the safety of individuals being served. Plans must be in writing and must include the following, as appropriate to the type of facility or service:

- Documentation of contact with the local emergency coordinator to determine local disaster risks and community-wide plans to address different disasters and emergencies and any assistance that the local emergency management office will provide to the facility in an emergency.
- Analysis of the provider's capabilities and potential hazards, including natural disasters, severe weather, fire, flooding, work place violence or terrorism, missing persons, severe injuries, or other emergencies, that would disrupt the normal course of service delivery.
- Written policies outlining specific responsibilities for:
 - Provision of administrative direction, situation assessment, management of response activities, and coordination of logistics during the emergency;
 - Communications and community outreach;
 - Ensuring the safety of employees, contractors, students, volunteers, visitors and individuals receiving services;
 - Protection, recovery, and restoration of property and vital records; and
 - Restoration of services.
- Emergency procedures addressing:
 - Communication with employees, contractors, and community responders;
 - Warning and notification of individuals receiving services;
 - Providing emergency access to secure areas and opening locked doors;
 - Conducting evacuations to emergency shelters or alternative sites and accounting for all individuals receiving services;
 - Relocating individuals receiving residential or inpatient services, if necessary;
 - Notifying family members and legal guardians;
 - Alerting emergency personnel and sounding alarms; and

- Locating and shutting off utilities when necessary.
- Supporting documents that would be needed in an emergency, including emergency call lists, building and site maps necessary to shut off utilities, designated escape routes, and lists of major resources such as local emergency shelters.
- Schedule for testing the implementation of the plan and conducting emergency preparedness drills.

The DBHDS *Comprehensive State Plan (2010-2016)*, its most recent, notes that numerous training sessions were held between 2007 and 2010 that addressed refinement of existing emergency preparedness plans, ensuring that recommendations by Community Services Boards (CSBs) are considered, and involvement of the Virginia Hospital and Healthcare Association's regional hospital emergency preparedness councils and the Medical Reserve Corps. Subsequently, several CSBs have adapted the DBHDS training curriculum to their needs and assumed responsibility for follow-up at their level.

Facilities licensed by DSS are required to review and update their plans, if necessary, on an annual basis, and DSS provides training for its licensed providers independently and in collaboration with the Virginia Department of Emergency Management (VDEM). DSS licensing inspectors determine whether a facility has an appropriate plan, either during routine licensing visits or in response to a complaint. There is limited coordination of this process with VDEM, which has the authority to review plans at the request of local emergency managers. As a part of its training and oversight, DSS encourages facilities to refer to the Special Facilities Emergency Operations Plan Review Matrix developed jointly by DSS, VDEM, VDH, DBHDS, and the Virginia Emergency Management Association (VEMA), which represents professionals working in emergency management and related fields such as firefighting, law enforcement, and risk management.

Virginia Office for Protection and Advocacy (VOPA): As the state agency responsible for addressing abuse, neglect, and discrimination affecting individuals with disabilities, VOPA has established the following objectives related to emergency preparedness in its listing of goals for federal fiscal year (FFY) 2011:

VOPA Goal: People with Disabilities are Free from Abuse and Neglect

Focus Area #1: Adequate System for Protection from Harm in Institutions

By April 1, 2011, investigate the implementation of a newly revised DBHDS instruction on emergency planning at one DBHDS-operated ICF-MR and one DBHDS-operated mental health facility. Publish the results.

Focus Area #2: Adequate System for Protection from Harm in Licensed Community Residential Settings

By April 1, 2011, review the newly revised emergency planning matrix for local community planners to ensure that concerns of persons with disabilities are adequately addressed. Make recommendations as appropriate.

G. Emergency Services Sources Referenced in This Chapter

Links to websites and online documents reflect their Internet addresses in March 2011. Some documents retrieved and utilized do not have a date of publication.

Websites:

U. S. Department of Homeland Security (DHS):

www.dhs.gov/files/prepresprecovery.shtm

Federal Emergency Management Agency (FEMA):

www.fema.gov/rebuild/index.shtm

National Response Framework:

www.fema.gov/emergency/nrf/

Links for Citizens:

www.dhs.gov/xcitizens/

Virginia Department for the Aging (VDA):

www.vda.virginia.gov

No Wrong Door:

www.vda.virginia.gov/nowrongdoor.asp

Virginia Department of Behavioral Health and Developmental Services (DBHDS):

www.dbhds.virginia.gov

Community Resilience Project:

www.dbhds.virginia.gov/OMH-DeafCommunityResilienceProject.htm

Helping to Heal:

www.dbhds.virginia.gov/CWD-HelpingToHeal.htm

Licensing All Other Services Except Children's Residential Services:

www.dbhds.virginia.gov/OL-Application.htm#Regulations

Licensing Children's Residential Services:

www.dbhds.virginia.gov/OL-ApplicationChild.htm

Tips for Teachers and Tips for Students:

www.dbhds.virginia.gov/CWD-EducationTemplate.htm

Virginia Department of Emergency Management (VDEM):

www.vaemergency.com

Virginia Citizen Corps:

www.vaemergency.com/citcorps/index.cfm

Virginia Department of Fire Programs (DFP):

www.VAFire.com

Virginia Department of Health (VDH):

www.vdh.virginia.gov

Emergency Preparedness and Response Programs:

www.vdh.virginia.gov/EPR/

Virginia Department of Health Professions (DHP):

www.dhp.virginia.gov

Virginia Department of Planning and Budget (DPB):

2010-2012 Biennium Budget:

<http://dpb.virginia.gov/budget/budget.cfm>

Virginia Department of Social Services (DSS):

www.dss.virginia.gov

Virginia Office for Protection and Advocacy (VOPA):

www.vopa.virginia.gov

Virginia Office of Veterans Affairs and Homeland Security (OVAHS):

www.commonwealthpreparedness.virginia.gov

Secretariat's Expenditures:

http://datapoint.apa.virginia.gov/exp/exp_checkbook_agency.cfm?agycode=454

State Inoperability Executive Committee (SIEC):

www.interoperability.virginia.gov

Virginia Olmstead Initiative:

www.olmsteava.com

Virginia Voluntary Organizations Active in Disasters (VA VOAD):

<http://vavoad.org/index.html>

Documents:

Roth, Marcie, Director, Office of Disability Integration and Coordination, Federal Emergency Management Agency, U.S. Department of Homeland Security. (June 15, 2010). *Caring for Special Needs during Disasters: What's being done for Vulnerable Populations?* Testimony before the U.S. House of Representatives, Committee on Homeland Security, Subcommittee on Emergency Communications, Preparedness, and Response. Retrieved from: www.fema.gov/pdf/about/odic/written_statement_roth.pdf.

State Interoperability Executive Committee (SIEC). (January 2010). *2010 Statewide Communication Interoperability Plan*. Retrieved from: www.interoperability.virginia.gov/pdfs/FinalFY2010StatePlan1_13_10.pdf.

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Appendix A.

Statewide Information and Advocacy Resources

Virginia's disability information services and advocacy programs are diverse and multilayered. They may operate independently or as a part of a larger agency or organization. Some of these resources and initiatives have been described in the most appropriate chapters of this assessment, usually in their introductions or under evaluation and monitoring. Others with statewide reach are included in this appendix.

Most government agencies and nongovernmental organizations have sections on their websites labeled Links, Resources, or something similar that contain lists of helpful documents and internet connections to sources of further assistance. Many agencies and organizations will also provide printed copies of documents in response to written, telephone, or e-mail requests. Some, but not all, provide their materials in foreign languages. Organizations receiving state and federal funding are required to provide information in alternate formats for individuals with disabilities who require reasonable accommodations to access the material.

The information below is not all-inclusive. Only organizations that have a statewide office or presence are listed, and the focus is on organizations that work with or provide information to persons with developmental disabilities and their families. Specific contact information for each is limited to its current website address because office addresses, telephone numbers, and e-mail addresses change more often than can be tracked by this assessment. For further information on these agencies or organizations and their programs, readers are encouraged to contact them directly.

2-1-1 VIRGINIA, www.211virginia.org: 2-1-1 is a service of the Virginia Department of Social Services (DSS) in partnership with the Council of Community Services, the Family Resource and Referral Center, CrisisLink, The Planning Council, the United Way of Virginia, and the United Way of Greater Richmond and Petersburg. By dialing 211 or visiting the service's interactive website, individuals can receive free information on available community services. Trained professionals respond to calls and e-mail inquiries submitted via the website with suggested resources that may be of assistance from a large database of health and human services in Virginia. Referrals are confidential, and the website includes a link to information on eligibility for benefits available through DSS. Government agencies, nonprofit community-based organizations, and businesses that provide health and human services for the citizens of Virginia are encouraged to list their services. Virginia Easy Access and SeniorNavigator, two interrelated and complementary resources, are also described in this listing.

American Civil Liberties Union of Virginia (ACLU), www.acluva.org: This private, nonprofit affiliate of the national ACLU promotes the civil liberties and civil rights of all residents through litigation, public education, and other activities. Its principal mission is "to protect constitutionally mandated freedoms that government tends to erode and to advance rights

clearly intended by the Constitution but never fully implemented in our society.” Issues relevant to individuals with disabilities that it addresses include, but are not limited to, free speech, religious rights, access to government, due process and criminal justice, privacy rights, and students’ rights.

The Arc of Virginia, www.arcofva.org: This nonprofit organization advocates with and on behalf of individuals with intellectual and developmental disabilities and their families for changes in state policies. It promotes the creation of individualized, self-determined, community-based supports that enable people with disabilities to lead productive, fulfilling lives. The Arc of Virginia’s 24 chapters across the state each provide a variety of services and supports for individuals with disabilities and their families appropriate to their communities’ needs. Together with the statewide organization, they provide training and technical assistance to service providers on strategies that enhance family involvement and share families’ perspectives with Virginia’s policymakers.

Autism Society of America (ASA) chapters: While there is no state chapter, local Autism Society affiliates have a strong statewide presence. Chapters include the Autism Society of Central Virginia (www.asacv.org), the Northern Virginia Chapter (www.asanv.org), the Tidewater Chapter (www.tidewaterasa.org), and the Peninsula Autism Society (www.peninsulautism.org). All of these chapters share information with individuals, families, and professionals on treatment, education, research, and advocacy. They hold support meetings, training, and other events and are active in legislative advocacy.

Autistic Self-Advocacy Network, www.autisticadvocacy.org: This nonprofit group seeks to advance the principles of the disability rights movement and change public perceptions about the capacity of individuals with autism spectrum disorders (ASDs). It works through public policy and community advocacy to encourage individuals to speak out for themselves on topics of interest to them.

Brain Injury Association of Virginia (BIAV), www.biav.net: BIAV’s nonprofit mission is to improve the quality of life of both persons with brain injury and their families and to support efforts to prevent brain injuries in Virginia. Services that it provides to individuals with brain injury, their families, service providers, and advocates include outreach to those affected by brain injuries, maintenance of an extensive clearinghouse of brain injury information, referrals for additional information and services, a toll-free Family Help Line, support groups, and training and recreation programs for individuals with brain injury and their families.

Center for Excellence in Autism Spectrum Disorders, www.vcuautismcenter.org: This collaboration of the Virginia Commonwealth University (VCU) Rehabilitation and Research Training Center (RRTC), VCU School of Education, and the Virginia Department of Education (VDOE), brings together experts and practitioners from a variety of fields who have varying professional perspectives related to autism spectrum disorders (ASDs). One of its first major initiatives has been to assist VDOE’s work to improve the responsiveness and quality of

programming provided for students with ASD by selected local school divisions across the Commonwealth.

Centers for Independent Living (CILs), www.vadrs.org/cbs/cils.htm: The federal *Rehabilitation Act* of 1973, as amended, authorizes CILs to provide services and advocacy that promote the leadership, independence, and productivity of people with significant disabilities. CILs are nonprofit, non-residential places of action and coalition where persons with disabilities become empowered and develop the skills necessary to make decisions and choices about their own lives. They work with individuals and local communities to remove barriers to independence and to ensure equal opportunities for persons with disabilities. All CILs provide the core services of advocacy for individuals and for system change, information and referrals, peer counseling, and training in independent living. Other services offered by CILs vary and may include, but are not limited to: disability awareness outreach, information on accessibility, educational advocacy, housing advocacy, and nursing home transition services, and general disability information and referrals. Additional information on CILs appears in the Community Supports chapter of this assessment.

The **Virginia Association of Centers for Independent Living (VACIL)**, www.vacil.org) provides guidance and policy support for the Commonwealth's CILs, represents them before the General Assembly on issues of importance, and has improved uniform practices among CILs in recent years through acquisition of grants. VACIL advocates for the inclusion and integration of individuals with disabilities in communities and promotes the professional development, improvement, and expansion of the community-based, consumer-controlled CILs.

Cerebral Palsy of Virginia, www.cerebralpalsyofvirginia.org: This nonprofit organization serves children and adults with cerebral palsy and other developmental disabilities such as Downs Syndrome, autism, muscular dystrophy, intellectual disabilities, and learning disabilities, as well as those who have vision, hearing, or speech impairments. It advocates on behalf of them and their families and provides programs and services to help them attain maximum independence and inclusion in their communities. Guidance is provided on the availability of assistive technology, adaptive toys, computer software, books, and other resources that are available for loan, allowing individuals to test and use these items in their home and ensure their effectiveness before making an expensive purchase.

Commonwealth Autism Service (CAS), www.autismva.org: This organization provides leadership and a statewide system of services to maximize the quality of life and potential of Virginians with autism spectrum disorders (ASD) across their lifespans. CAS advocates for implementation of best practices for treatment and for state policy changes that improve service access and availability. In recent years, it has been partially funded by the Virginia General Assembly to provide ongoing support for families and professionals, develop regional service networks, provide technical assistance and training, and conduct conferences. It has developed and implemented a successful model of instructional support for students with ASD in classrooms across the state.

Housing Opportunities Made Equal (HOME) of Virginia, www.phonehome.org: Located in Richmond, HOME is certified by both the Virginia Real Estate Board and the Virginia Fair Housing Board to provide fair housing classes covering topics such as money management, tenant's rights, purchasing a home, fair housing reasonable accommodations, and home modifications. Courses are offered to the general public periodically throughout the year and can also be arranged for a company or other group upon request. HOME also helps income-eligible Virginians afford a home purchase by providing financial assistance to cover closing costs and down payments.

Human Rights Council of Virginia, <http://chr.vipnet.org/index.html>: Formerly called the Council on Human Rights, the Council safeguards individuals from discrimination on the basis of race, color, religion, national origin, gender, age, disability, or pregnancy/childbirth related medical conditions. In addition to promoting public awareness of human rights for all citizens of the Commonwealth, it is empowered under Chapter 39 of the *Virginia Human Rights Act* (2.2-3900A, *et seq.*) to investigate complaints under that statute as well as Title VII of the federal *Human Rights Act* of 1964, as amended; the *Americans with Disabilities Act* (ADA); and the *Age Discrimination in Employment Act*. It has jurisdiction in specified matters relating to public accommodations, including educational institutions, real estate transactions, and employment. The Council receives and reviews discrimination complaints in these areas of its jurisdiction, attempts mediation, conducts investigations, and renders determinations.

Long-Term Care Ombudsman Program, www.elderrightsva.org: The national *Older Americans Act* requires all states to provide advocacy services for older persons receiving long-term care. The Virginia Department for the Aging (VDA) contracts with the 25 local **Area Agencies on Aging (AAA)** to provide these services through the Long-Term Care Ombudsman Program. The State Ombudsman, who has expertise in both long-term care and advocacy, coordinates and supports designated local ombudsmen who completed a certification curriculum and then identify, investigate, and resolve complaints made by or on behalf of older persons. Individuals needing advocacy services can contact the ombudsman at their local AAA directly or through VDA's statewide toll-free telephone hotline.

The March of Dimes of Virginia, www.marchofdimes.com: Headquartered in Richmond, with offices in Roanoke, Harrisonburg, and Chesapeake, this organization conducts research, community outreach, education, and advocacy to improve the lives of babies by preventing birth defects, premature birth, and infant mortality.

Medicaid Waiver Technical Assistance Center (MWTAC), www.endependence.org (under Services): This center provides materials and workshops with detailed information about Virginia's Medicaid Home and Community Based Services (HCBS) Waivers to assist individuals with disabilities and their families understand how to access services available under these waivers. Funding from the Virginia Board for People with Disabilities (VBPD) has supported the work of MWTAC, including initiation and ongoing communications support of the **Medicaid Waiver Advocacy Network** affiliated with MWTAC. This independent, voluntary network of individuals and representatives of organizations across the state with expertise in

Medicaid HCBS Waivers is committed to improving knowledge of and access to waiver services.

Medical Home Plus, www.medhomeplus.org: This nonprofit organization facilitates family, professional, and community partnerships to create a more seamless service delivery system that improves the quality of life for children with special health care needs or disabilities. Its website includes information for medical professionals and a family resource center detailing laws related to special needs, financing of a child's needs, planning for education and future needs, referral resources, preventative services, and information regarding diagnosis-specific conditions such as autism.

Mental Health America of Virginia (MHAV), www.mhav.org: This nonprofit, nonpartisan organization promotes mental health, develops services to prevent mental illness, and works to ensure that children and adults with mental illness receive proper care and treatment. It advocates for public and private sector policies, services, and financing to ensure adequate and appropriate detection, treatment, and rehabilitation for mental illness and for housing and other supports. It raises public awareness of mental illness in order to eliminate the stigma that prevents individuals from seeking help when they need it.

The Muscular Dystrophy Association (MDA), www.mda.org: This volunteer health agency, founded in 1950 by adults with muscular dystrophy (MD) and parents of children with MD, seeks to conquer neuromuscular diseases that affect more than a million Americans. Its national website contains information and educational resources for families, including a zip-code-based locator to assist them in finding local offices which can direct them to other community and governmental organizations for assistance. MDA's Virginia offices are located in Richmond, Hampton Roads, Chesapeake, and Fairfax.

National Alliance on Mental Illness (NAMI) of Virginia, www.namivirginia.org: This organization provides information and support for those affected by mental illness, including teens, family members, friends, veterans, and others. It maintains a hotline for information on mental illness and makes referrals to local self-help groups that provide support, share additional information on community services, and advocate on behalf of individuals with mental illness and their families. NAMI of Virginia's Richmond office is responsible for state-level policy and legislative advocacy.

Office of Human Rights (OHR), www.dbhds.virginia.gov/OHR-default.htm: This office within the **Virginia Department of Behavioral Health and Developmental Services (DBHDS)** fulfills the *Code of Virginia* (37.1-84.1) requirement for protection of legal and human rights of individuals with mental illness, intellectual disability, or substance abuse disorder who receive services in facilities or programs operated, licensed, or funded by that agency. OHR monitors compliance with state human rights regulations, promotes the basic precepts of human dignity, advocates for the rights of persons with disabilities, and manages the human rights dispute resolution program. More information can be found in the monitoring and evaluation section of the Community Supports chapter of this assessment.

Parent Education Advocacy Training Center (PEATC), www.peatc.org: Funded by a grant from the U.S. Department of Education, PEATC is Virginia's parent education, support, training, and information center committed to building better futures for children with disabilities. PEATC staff work collaboratively with families, schools, and service professionals to improve opportunities for excellence in education as well as personal success in school and community life. Its disability information development and training curricula for families and professionals are easy to understand, experience-based, and research-tested. It also provides information on the *Comprehensive Services Act*, foster care, transition services, and other areas of interest to families.

Parent Resource Centers (PRCs), funded by the Virginia Department of Education (VDOE) and found in most but not all school divisions, work closely with PEATC. Drawing on a variety of state and community resources, they are a local source of assistance, referrals, and workshops on special education issues for parents and educators. A list of PRCs across Virginia can be found at www.doe.virginia.gov/special_ed/parents/parent_resource_centers.pdf.

Parent to Parent (PTP) of Virginia, www.ptpofva.com: This program brings together parents of children with disabilities and special health care needs to serve as mentors for one another, exchange information, and provide peer support. It also develops educational materials, sponsors training workshops, and advocates for family-directed care and supports that enable children with special medical needs to live in communities with their families.

Parents of Autistic Children (POAC), www.poac-nova.org: This organization, which began in the early 1990s in northern Virginia, principally Fairfax County, became statewide in 2007. It serves as a clearinghouse for research-based instructional methodologies for students with autism spectrum disorders (ASD), advocates for their use in public and private schools, and provides training to enable successful implementation.

Partnership for People with Disabilities (PPD), www.vcu.edu/partnership: The Partnership, as it is commonly referenced, at **Virginia Commonwealth University** is Virginia's University Center for Excellence in Developmental Disabilities as authorized by the federal *Developmental Disabilities and Bill of Rights Act* of 2000 (DD Act). It operates more than 30 state and federally funded programs, staffed by more than 100 professionals and students, who provide support for individuals with disabilities and their families. Its activities are diverse and include, but are not limited to: advocacy on issues affecting individuals with disabilities and their families, promotion of changes to related state policies, training, and development of resources for families and professionals. Early intervention, education, health, and self-advocacy are among the many topics that those activities address. The Partnership maintains an interdisciplinary approach in all its activities as it strives to create communities in which all people, with and without disabilities, can live, work, and play together with choices and independence. Its collaborators include disability service providers, elementary and secondary schools and school divisions, higher education, state and local agencies, and professional organizations.

SeniorNavigator, www.SeniorNavigator.org: This private, nonprofit organization has grown out of a collaboration of the Virginia Department for the Aging (VDA), local governments, and hundreds of private sector participants to become a national model for aging and disability information and service referrals. Individuals seeking assistance can now access more than 23,000 health and community support resources for seniors, adults with disabilities, their families, and caregivers online directly or through a statewide network of volunteers. At the time of this assessment, a grant from the Virginia Board for People with Disabilities is enabling SeniorNavigator to further expand its network of VirginiaNavigator Centers operated in partnership with local and regional governmental and nongovernmental organizations. 2-1-1 Virginia and Virginia Easy Access, two interrelated and complementary resources, are also described in this listing.

vaACCSES (Virginia Association of Community Rehabilitation Programs),

www.vaACCSES.org: Members of this association provide employment, day support, training, and support services for persons with disabilities. vaACCSES advocates on public policy areas of interest to its members and provides educational resources and training for them, other service providers, individuals with disabilities, and their families. Training topics include work incentives for Supplemental Security Income (SSI) or Social Security Disability Income (SSDI) beneficiaries. vaACCSES is also a Work Incentives Planning and Assistance (WIPA) project under the federal *Ticket to Work and Work Incentives Improvement Act*, providing benefits counseling to individuals who wish to work but need to maintain public benefits such as Medicaid. Additional information on work incentives can be found in the Employment chapter of this assessment.

Virginia Advocates United Leading Together (VAULT), www.virginiavault.org: Created through a collaboration of Virginia self-advocates and disability organizations with support from the Virginia Board for People with Disabilities and Partnership for People with Disabilities at Virginia Commonwealth University, this new organization fulfills a mandate under the federal *Developmental Disabilities Act* that the Board support a statewide organization led by self-advocates. VAULT applied for federal 501(c)(3) tax-exempt status in April 2011, and its inaugural Board of Directors included representatives from the Autistic Self-Advocacy Network, Hearing Loss Association, People First, Virginia Association of Centers for Independent Living (VACIL), Virginia Association of the Deaf-Blind, Virginia Organization of Consumers Asserting Leadership (VOCAL), and Youth Leadership Forum alumni.

Virginia Alliance for Community: This collaboration of The Arc of Virginia, the Virginia Board for People with Disabilities, the Partnership for People with Disabilities at Virginia Commonwealth University, and the Virginia Office for Protection and Advocacy was created in 2008 as a united advocacy voice for the civil rights of Virginians with intellectual and developmental disabilities. More than 100 public and private agencies and organizations subsequently expressed support for its “Community for All” message requesting that the Governor and legislature build capacity for community services and redirect funds from costly

institutional residential settings to community-based alternatives. Additional information can be found at www.thearcofva.org/advocacy/vaac.html and www.vaboard.org/vapolicy.htm.

Virginia Assistive Technology System (VATS), www.vats.org: This statewide program, authorized and funded by the federal *Assistive Technology Act* of 2004, as amended, and administered by the Virginia Department of Rehabilitative Services (DRS), promotes public awareness and provides training and technical assistance about the availability and use of assistive technology for people with disabilities. Staff at its central and three regional offices demonstrate or assist with training on specific devices, provide information on equipment sources, and coordinate an equipment exchange program and statewide network of recycling programs. They can also provide information on low-interest loans that make devices more affordable. More detailed information on VATS and other assistive technology resources is available in the Community Supports chapter of this assessment.

Virginia Association of Area Agencies on Aging (VAAAA), www.vaaaa.org: This private, nonprofit organization supports information sharing, training, and other educational activities for and by the state's Area Agencies on Aging (AAAs) in their work on behalf of older Virginians and their families. It also serves as the AAAs' liaison with the Virginia Department for the Aging (VDA) and other state and national public and private organizations working on aging issues.

Virginia Association of Community Services Boards (VACSB), www.vacsb.org: As the statewide organization for Virginia's network of 37 local Community Services Boards (CSBs) and three Behavioral Health Authorities (BHAs), the VACSB represents those local service providers on matters of state and federal public policy, including funding, legislation, and regulation. VACSB advocates on behalf of the CSBs and BHAs, engages in public education activities, and promotes the improvement and expansion of an accessible, affordable, statewide public system providing prevention, treatment, and rehabilitation services for individuals with mental illness, intellectual disabilities, or substance abuse disorders. The VACSB website offers e-learning opportunities, conference information, legislative updates, and links to other resources and services for individuals with disabilities and their families.

Virginia Autism Resource Center (VARC), www.varc.org: At the time of this assessment, Virginia Commonwealth University plans to merge VARC into its new Center for Excellence in Autism Spectrum Disorders (ASD), previously described in this appendix. Until then, VARC continues to serve as a separate resource. It provides information and referral, training on evidence-based best practices, and direct consultations for individuals with ASD, their families, professionals, school divisions, and other agencies. It also maintains an extensive internet lending library and assists professionals pursuing a Certificate on Autism Spectrum Disorders baccalaureate degree.

Virginia Board for People with Disabilities (VBPD), www.vaboard.org: The author of this assessment, often referred to simply as the Virginia Board, is the Commonwealth's federally authorized Developmental Disabilities (DD) Planning Council under the *Developmental*

Disabilities and Bill of Rights Act of 2000 (DD Act). DD Councils are mandated by federal statute to engage in advocacy to promote systems change and barrier elimination that will build service capacity and contribute to the development of a coordinated, comprehensive system of services, individualized supports, and other forms of assistance for individuals with developmental and other disabilities. In fulfilling this mandate, the Virginia Board supports public and private policies and practices that enable Virginians with disabilities to live successfully in communities of their own choice with access to individually appropriate services and supports. Through its advocacy, policy, and investment activities, the Board leverages public and private funds and works in partnership with numerous organizations, state and local agencies, private nonprofit service providers, and institutions of higher education throughout the state to increase the independence, productivity, and integration of people with disabilities. The activities that it conducts directly or funds include educating policymakers, demonstrating new approaches to services and supports, leadership and advocacy training for individuals with disabilities and their family members, self-advocacy, research, outreach, information distribution, and expanded public awareness.

Virginia Department of Education (VDOE) Ombudsman Program, www.doe.virginia.gov/special_ed/resolving_disputes/ombudsman/index.shtml: The VDOE Ombudsman acts as a source of information and referral, answers individuals' questions, and assists in the resolution of concerns and issues. The program serves as a resource for parents in non-legal special education matters and does not provide direct advocacy. No formal complaint forms or documentation are involved. The interests and rights of all parties involved are taken into account in considering any given instance or concern. The Ombudsman's role is neutral as an independent advocate for a fair process, encouraging all parties to resolve differences at the lowest organizational level possible through appropriate informal or formal dispute-resolution processes. There is a focus on listening and providing information, discussing issues and options, and making referrals to other services, including mediation.

Virginia Easy Access, www.easyaccess.virginia.gov: This interactive, online gateway to information on public and private long-term services and supports for older adults and adults with disabilities was developed in partnership by the Commonwealth of Virginia, SeniorNavigator, and 2-1-1 Virginia as a part of the state's **No Wrong Door** initiative. Three different search functions allow users to access the extensive **VirginiaNavigator** database of service providers and other resources related to community supports, emergency preparedness, finances, housing, transportation, legal rights, veterans' issues, and other topics. Telephone and e-mail support for the website is provided by 2-1-1 Virginia. SeniorNavigator and 2-1-1 Virginia, two interrelated and complementary resources, are also described in this listing.

Virginia Fair Housing Office, www.dpor.virginia.gov/dporweb/fho_index.cfm: Details on discrimination prohibited by fair housing laws and of the processes for investigating and resolving complaints under those laws may be found in the Housing chapter of this assessment. In addition to its role in these processes, the Fair Housing Office provides free training for state and local officials, housing providers, and individuals.

Virginia Housing Search, www.virginiahousingsearch.com: This housing locator service, launched by the Virginia Housing Development Authority (VHDA) in 2009, provides detailed information about rental properties and helps people find housing that best fits their needs. It can be accessed at no cost, 24 hours per day online or Monday through Friday, 9:00 a.m. to 8:00 p.m. Eastern Time, using a toll-free, bilingual call center. Individuals can search for rental housing using a wide variety of criteria and special, accessible mapping features, and listings provide detailed information on each available unit. The service also provides links to housing resources and helpful tools for renters such as an affordability calculator, rental checklist, and information on renters' rights and responsibilities.

Virginia Legal Aid, www.valegalaid.org: Free or low cost legal services are provided for individuals with low incomes on matters such as immigration, health care, family and domestic violence, elder law, debt and consumer issues, criminal defense, employment, education, benefits, and housing. In addition, educational materials and referrals on topics including debtor's rights, elder law, and eligibility for social and other services are available from the central education site in Richmond and satellite offices in Charlottesville, Harrisonburg, Lexington, Petersburg, Roanoke, and other locations across the state. The website contains an electronic listing of all offices in Virginia, and not all services are available at all offices.

The **Legal Aid Justice Center** (www.justice4all.org), the legal aid entity based in Charlottesville, performs significant work in the area of disability. Its **Civil Advocacy Program** addresses legal issues in housing, public benefits, employment, consumer protection, and the rights of the elderly and individuals with disabilities. Its **JustChildren** program works to ensure that young people have access to the services and supports necessary for them to live successfully in their communities by providing direct legal services for local families with children from birth to age 18 through its offices in Charlottesville, Richmond, and Petersburg. It also engages in statewide advocacy on important issues affecting Virginia children. Legal representation is provided in matters concerning appropriate education services for children with disabilities, necessary treatment services for children with psychiatric concerns, and services and supports required for children involved with the juvenile courts to remain in their communities. JustChildren also engages in community education and works with other statewide advocacy efforts involving foster care, the juvenile justice system, and other issues.

Virginia Office for Protection and Advocacy (VOPA), www.vopa.virginia.gov: As the Commonwealth's federally authorized and funded Protection and Advocacy entity under the *Developmental Disabilities and Bill of Rights Act* of 2000 (DD Act), VOPA's mission is to "protect and advance the legal, human, and civil rights of persons with disabilities; combat and prevent abuse, neglect, and discrimination; and promote independence, choice, and self-determination by persons with disabilities." It is also authorized in state statute as an independent state agency but does not receive any state funds. Because VOPA does not have unlimited funds, priorities and goals for its activities are set annually by its governing board. All individuals who contact VOPA requesting assistance receive appropriate information or referrals; however, only individuals with problems targeted in VOPA's goals and priorities may

be provided with advocacy or legal assistance. Information on VOPA's programs, goals, and objectives can be obtained on its website or by calling its toll-free telephone line.

Virginia Organization of Consumers Asserting Leadership (VOCAL),

www.vocalvirginia.org: Initially formed to address mental health and mental illness concerns, VOCAL is increasingly involved in providing services for individuals with multiple disabilities, including intellectual disabilities. The VOCAL Network is a statewide coalition of individuals with disabilities and their families united to provide a voice for individual empowerment and to foster a mental health system driven by individuals with disabilities themselves. Coalition partners act as peer mentors and work with other advocacy organizations to protect individual rights and to fight discrimination, encourage the exchange of information, build service system capacity, improve state mental health policies, and increase the well-being of individuals with mental illness, intellectual disabilities, or substance abuse problems.

Virginia Poverty Law Center (VPLC), www.vplc.org: This nonprofit organization advocates on poverty issues of statewide importance on behalf of Virginians with low incomes. VPLC supplies local legal aid staff members, private attorneys, and people with low incomes with technical assistance, training, and publications that exclusively address the legal rights of Virginia's poor. It also sponsors an annual legal aid conference and provides assistance with legislative and administrative proposals affecting Virginians with low incomes. VPLC areas of interest include health care, housing, public benefits, and consumer, elder, and family rights.

Voices for Virginia's Children, www.vakids.org: Established in 1994 to champion public policies in the interest of Virginia's children, this statewide research and advocacy organization conducts policy analyses and distributes reports on multiple issues, including federal spending trends and tax policies. It also conducts research regarding children living in poverty, provides information on domestic and international adoptions, and raises awareness of issues, forms coalitions, and organizes grassroots advocacy efforts. Its areas of focus have included improvements to permanent planning for youth in foster care, supports for immigrant families, and improved access to quality preschool education for all children.

Appendix B: Acronyms

A

AAA: Area Agency on Aging
 AAC: Alternative/Augmentative Communications (Devices)
 AAIDD: American Association for Intellectual and Developmental Disabilities
 AAL: Alzheimer's Assisted Living (Waiver)
 AAR: After-Action Report
 ABA: Applied Behavioral Analysis
 ABCD: Assuring Better Child Health and Development (Screening Academy)
 ACF: U.S. Administration for Children and Families
 ACLU: American Civil Liberties Union
 ACYF: U.S. Administration on Children, Youth, and Families
 ADA: *Americans with Disabilities Act*
 ADC: Average Daily Census
 ADD: U.S. Administration on Developmental Disabilities
 ADL: Activities for Daily Living
 ADM: Average Daily Membership
 ADRC: Aging and Disability Resource Center (Grant)
 ADS: Additional Daily Supervision
 AFC: Adult Foster Care
 AHEC: Area Health Education Center
 AIDS: Acquired Immune Deficiency Syndrome
 ALF: Assisted Living Facility
 ALOS: Average Length of Stay
 AOA: U.S. Administration on Aging
 APA: Virginia Auditor of Public Accounts
 APR: Annual Performance Report

APS: Adult Protective Services
 ASA: Autism Society of America
 AUCD: Association of University Centers on Disability
 ARDRSAS: Annual Report on the Dispute Resolution Systems and Administrative Services
 ARRA: *American Recovery and Reinvestment Act*
 ASAPS: Adult Services and Adult Protective Services
 ASD: Autism Spectrum Disorder
 ASL: American Sign Language
 ASPR: U.S. Assistant Secretary for Preparedness and Response for Health and Human Services
 AT: Assistive Technology
 ATLFA: (Assistive Technology Loan Fund Authority) NewWell Fund
 AYP: Average Yearly Progress

B

BCCEDP: VDH Breast and Cervical Cancer Early Detection Program
 BHDS: Behavioral Health and Developmental Services (Trust Fund)
 BI: Brain Injury
 BIAV: Brain Injury Association of Virginia
 BIDS: DRS Brain Injury Direct Services (Fund)
 BIS: WWRC Brain Injury Services
 BISC: DRS Brain Injury Services Coordination (Unit)
 BHA: Behavioral Health Authority
 BOB: Business Opportunities for the Blind
 BRFSS: (Virginia) Behavioral Risk Factor Surveillance System

C

CANS: Child and Adolescent Needs and Strengths

CARF: Commission on Accreditation of Rehabilitation Facilities

CAS: Commonwealth Autism Services

CBO: U.S. Congressional Budget Office

CCC: VDH Care Connection for Children

CDBG: U.S. Community Development Block Grant

CDC: U.S. Centers for Disease Control and Prevention

CDS: VDH Child Development Services

CDSMP: VDH Chronic Disease Self-Management Program

CERT: Community Emergency Response Team

CFR: Center for Research (in Meridian, Connecticut)

CFR: Code of Federal Regulations

CHIP: (State) Children's Health Insurance Program

CHSM: Coordinated Human Service Mobility (Plan)

CICO: Commonwealth Interoperability Coordinator's Office

CIL: Center for Independent Living

CMS: U.S. Centers for Medicare and Medicaid Services

CoC: Continuum of Care

COLA: Cost of Living Adjustment

COMLINC: Commonwealth's Link to Interoperable Communications

ConPlan: Consolidated Plan

COOP: Continuity of Operations (Plan)

CoPA: Communities of Practice in Autism

COPN: Certificate of Public Need

CORE: Standards for Interdepartmental Regulation of Children's Residential Facilities

COVEOP: Commonwealth of Virginia Emergency Operations Plan

CPMT: Community Policy and Management Team

CPS: Child Protective Services

CPS: Current Population Survey

CRCM: DRS Community Rehabilitation Case Management (Services)

CRIPA: *Civil Rights of Institutionalized Persons Act*

CRT: Crisis Response Team

CSA: *Comprehensive Services Act*

CSB: Community Services Board

CSHCN: VDH Children with Special Health Care Needs

CSP: Consumer Service Plan

CSU: Crisis Stabilization Unit

CVTC: DBHDS Central Virginia Training Center

CYSHCN: VDH Children and Youth with Special Health Care Needs

D

DBHDS: Virginia Department of Behavioral Health and Developmental Services

DBVI: Virginia Department for the Blind and Vision Impaired

DD: Developmental Disability

DDHH: Virginia Department for the Deaf and Hard of Hearing

DHCD: Virginia Department of Housing and Community Development

DHP: Virginia Department of Health Professions

DMA: Virginia Department of Military Affairs

DMAS: Virginia Department of Medical Assistance Services

DME: Durable Medical Equipment

DMHMRSAS: Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services (Now DBHDS)

CNA: Certified Nursing Assistant

CNI: Commonwealth Neurotrauma Initiative

DEI: Disability Employment Initiative

DGS: Virginia Department of General Services

DHHS: U.S. Department of Health and Human Services

DHS: U.S. Department of Homeland Security

DJJ: Virginia Department of Juvenile Justice

DMV: Virginia Department of Motor Vehicles

DOA: Virginia Department of Accounts

DOE: U.S. Department of Education

DOJ: U.S. Department of Justice

DOLETA: U.S. Department of Labor Employment and Training Administration

DPN: Disability Program Navigator

DPOR: Virginia Department of Professional and Occupational Regulation

DRPT: Virginia Department of Rail and Public Transportation

DRS: Virginia Department of Rehabilitative Services

DSB: Disability Services Board

DSA: Disability Services Agencies

DSP: Disabilities Service Plan

DSS: Virginia Department of Social Services

E

EDCD: Elderly or Disabled with Consumer Direction (Waiver)

EES: Extended Employment Services

EI: Early Intervention

EHS: Early Head Start

EMAC: Emergency Management Accreditation Program

EMS: Emergency Medical Services

EN: Employment Network

EOP: Emergency Operations Plan

EPSDT: Early and Periodic Screening, Diagnosis, and Treatment

ESF: Emergency Support Function

ESO: Employment Service Organization

ESY: Extended School Year

ETA: U.S. Employment Training Administration

ETC: Empowerment through Communication (Program)

F

FAMIS: Family Access to Medical Insurance Security

FAPE: Free Appropriate Public Education

FAPT: Family Assessment and Planning Team

FEMA: Federal Emergency Management Agency

FFP: Federal Financial Participation

FFY: Federal Fiscal Year

FHB: Fair Housing Board

FMAP: Federal Medical Assistance Percentage (Funding)

FPL: Federal Poverty Level

F.R.E.E.: Foundation for Rehabilitation Equipment and Endowment

FTA: Federal Transit Administration

FY: Fiscal Year

G

GED: General Educational Development
(Certificate)

GIS: Geographic Information Systems

GMU: George Mason University

H

HCBS: Home and Community Based
Services

HHR: Virginia Secretary/Secretariat of
Health and Human Resources

HHS: U.S. Department of Health and Human
Services

HIP: Homeless Intervention Program

HIV: Human Immunodeficiency Virus

HJR: House Joint Resolution

HOME: Housing Opportunities Made Equal

HOPWA: Housing Opportunities for Persons
with AIDS

HPPD: Health Promotion for People with
Disabilities

HRSA: U.S. Health Resources and Services
Administration

HSGP: U.S. Homeland Security Grant
Program

HUD: U.S. Department of Housing and
Urban Development

I

ICF-MR: Intermediate Care Facility for
Persons with Mental Retardation

ID: Intellectual Disability

IDEA: *Individuals with Disabilities
Education [Improvement] Act*

IEE: Independent Educational Evaluation

IEP: Individualized Education Program

IFSP: Individualized Family Services Plans

IHP: Individuals and Households Program

IPE: Individual Plan for Employment

IPP: Individual Program Plan

IRS: U.S. Internal Revenue Service

IRWE: Impairment-Related Work Expenses

ISP: Individual Services Plan

ITOTS: Infant and Toddler Online Tracking
System

J

JARC: Job Access and Reverse Commute
Program

JLARC: Virginia Joint Legislative Audit and
Review Commission

L

L2O: Loan-to-Own

LCA: Local Contact Agency

LEA: Local Education Agency

LHRC: Local Human Rights Committee

LICC: Local Interagency Coordinating
Council

LIHTC: Low-Income Housing Tax Credit

LCAR: Local Capability Assessment of
Readiness

LOF: Level of Functioning (Survey)

LRE: Least Restrictive Environment

LTESS: Long-Term Employment Support
Services

M

MCH: Maternal and Child Health (Block
Grant)

MCO: Managed Care Organization

MDA: Muscular Dystrophy Association

MEQC: Medicaid Eligibility Quality Control

MFP: Money Follows the Person

MH: Mental Health

MHAV: Mental Health America of Virginia

MI: Mental Illness
 MIG: Medicaid Infrastructure Grant
 MMRS: Metropolitan Medical Response System
 MOE: Maintenance of Effort
 MOU: Memorandum of Understanding
 MR: Mental Retardation
 MRC: Medical Reserve Corps
 MTAC: Medicaid Transportation Advisory Council
 MWWTAC: Medicaid Waiver Technical Assistance Center

N

NAIC: National Association of Insurance Commissioners
 NAMI: National Association on Mental Illness
 NCLB: No Child Left Behind
 NF: Nursing Facility
 NFCSP: National Family Caregiver Support Program
 NGO: Nongovernmental Organization
 NICU: Neonatal Intensive Care Unit
 NIMBY: Not In My Back Yard
 NMEDA: National Mobility Equipment Dealers Association
 NOFA: Notice of Funding Availability
 NRF: National Response Framework
 NVTC: DBHDS Northern Virginia Training Center

O

OAG: Office of the Attorney General of Virginia
 OBRA: *Omnibus Budget Reconciliation Act*
 OCL: DBHDS Office of Community Contracting

OCP: Virginia Office of Commonwealth Preparedness
 OCS: Virginia Office of Comprehensive Services for At-Risk Youth and Families
 ODS: DBHDS Office of Developmental Services
 OEMS: VDH Office of Emergency Medical Services
 OEP: VDH Office of Emergency Preparedness
 OFPM: VDOE Office of Federal Program Monitoring
 OHR: DBHDS Office of Human Rights
 OIG: Office of the Inspector General of Behavioral Health and Developmental Services
 OL: DBHDS Office of Licensing
 OLC: VDH Office of Licensure and Certification
 ORCE: VDH Office of Risk Communications and Education
 OSCAR: Online Survey, Certification, and Reporting (System)
 OSEP: U.S. Office of Special Education Programs
 OVAHS: Virginia Office of Veterans Affairs and Homeland Security

P

PA: Personal Attendant
 PACE: Program for All-Inclusive Care for the Elderly
 PAIR: Parents and Associates of the Institutionalized Retarded
 PALS: Phonological Awareness Literacy Screening
 PAS: Personal Assistance Services
 PASRR: Pre-Admission Screening and Resident Review

PASS: Plan for Achieving Self Support
 PCIS: Patient Care Information System
 PCP: Person-Centered Planning
 PCT: Person-Centered Thinking
 PDA: Personal Digital Assistant
 PEATC: Parent Educational Advocacy Training Center
 PERS: Personal Emergency Response System
 PERT: Postsecondary Education/Rehabilitation Transition
 PHA: Public Housing Agencies
 PL: U.S. Public Law
 POAC: Parents of Autistic Children
 POC: Plan of Care
 PPACA: *Patient Protection and Affordable Care Act*
 PPD: VCU Partnership for People with Disabilities
 PRC: Parent Resource Center
 PRISM: Program Review Instrument for Systems Monitoring
 PTP: Parent to Parent of Virginia

Q

QHWRA: *Quality Housing and Work Responsibilities Act*
 QMR: Quality Management Review
 QMRP: Qualified Mental Retardation Professional

R

RCSC: DBHDS Regional Community Support Center
 REB: Real Estate Board
 RFA: Request for Application
 RFP: Request for Proposal
 RRTC: VCU Rehabilitation Research and Training Center

RSA: U.S. Rehabilitation Services Administration
 RT/IL: DBVI Rehabilitation Teaching/Independent Living
 RTI: Response to Intervention (Program)

S

SACT: State Agencies Coordinating Transportation (Work Group)
 SAFETEA-LU: *Safe, Accountable, Flexible, Efficient Transportation Equity Act—Legacy for Users*
 SCC: Virginia State Corporation Commission
 SCHIP: State Children’s Health Insurance Program
 SCI: Spinal Cord Injury
 SCIP: Statewide Communication Interoperability Plan
 SE: Supported Employment
 SEAC: Special Education Advisory Committee
 SELN: State Employment Leadership Network
 SFY: State Fiscal Year
 SEVTC: DBHDS Southeastern Virginia Training Center
 SHHR: Virginia Secretary/Secretariat of Health and Human Resources
 SHSP: U.S. State Homeland Security Program
 SIEC: State Interoperability Executive Committee
 SILC: Statewide Independent Living Council
 SIS: Supports Intensity Scale
 SLAT: State and Local Advisory Team
 SMA: (Virginia) Statewide Mutual Aid
 SMS: State-Managed Shelter
 SNF: Skilled Nursing Facility

SOL: Standards of Learning
 SOP: State-Operated Program
 SOQ: Standards of Quality
 SPA: State Plan Amendment
 SPP: State Performance Plan
 SQT: Substandard Quality of Care
 SSA: U.S. Social Security Administration
 SSCC: Sentara Senior Community Care
 SSDI: Social Security Disability Income
 SSEAC: State Special Education Advisory Committee
 SSI: Supplemental Security Income
 STARS: Virginia State Police Statewide Agency Radio System
 STG: Systems Transformation Grant
 SVTC: DBHDS Southside Virginia Training Center
 SWVTC: DBHDS Southwestern Virginia Training Center

T

TA: Technical Assistance
 TAC: Technical Assistance Collaborative, Inc.
 TANF: Temporary Assistance for Needy Families
 TAP: DDHH Technology Assistance Program
 TBI: Traumatic Brain Injury
 TDO: Temporary Detention Order
 Tech: Technology Assisted (Waiver)
 THA: Transportation and Housing Alliance
 T/TA: Training and Technical Assistance (Center)
 TTY: Teletypewriter

U

UAI: Uniform Assessment Instrument

UASI: Urban Areas Security Initiative
 UCP: United Cerebral Palsy

V

VA: U.S. Veterans' Administration
 VAAAA (V4A): Virginia Association of Area Agencies on Aging
 vaACCSES: Virginia Association of Community Rehabilitation Programs
 VAAP: Virginia Alternate Assessment Program
 VAC: Virginia Administrative Code
 VaCARES: Virginia Congenital Anomalies Reporting and Education System
 VACIL: Virginia Association of Centers for Independent Living
 VACSB: Virginia Association of Community Services Boards
 VADOC: Virginia Department of Corrections
 VARC: Virginia Autism Resource Center
 VATS: Virginia Assistive Technology System
 VAULT: Virginia Advocates United Leading Together
 VA VOAD: Virginia Voluntary Organizations Active in Disasters
 VBDP: VDH Virginia Bleeding Disorders Program
 VBPD: Virginia Board for People with Disabilities
 VCCS: Virginia Community College System
 VCU: Virginia Commonwealth University
 VDA: Virginia Department for the Aging
 VDACS: Virginia Department of Agriculture and Consumer Services
 VDEM: Virginia Department of Emergency Management
 VDFFP: Virginia Department of Fire Programs

VDH: Virginia Department of Health
 VDOE: Virginia Department of Education
 VDOT: Virginia Department of Transportation
 VEC: Virginia Employment Commission
 VEHDIP: VDH Virginia Early Hearing Detection and Intervention Program
 VEMA: Virginia Emergency Management Association
 VEMAT: Virginia Enhanced Maintenance Tool
 VERT: Virginia Emergency Response Team
 VFHO: Virginia Fair Housing Office
 VHDA: Virginia Housing and Development Authority
 VHRI: Virginia Health Reform Initiative (Advisory Council)
 VIB: Virginia Industries for the Blind
 VICAP: Virginia Insurance Counseling and Assistance Program
 VICC: Virginia Interagency Coordinating Council
 VIDA: Virginia Individual Development Account (Program)
 VIPER: Virginia Interoperability Picture for Emergency Response
 VIPS: Volunteers In Public Service
 VNPP: Virginia Network of Private Providers
 VOCAL: Virginia Organization of Consumers Asserting Leadership
 VOPA: Virginia Office for Protection and Advocacy
 VPLC: Virginia Poverty Law Center
 VR: Vocational Rehabilitation
 VRCBVI: DBVI Virginia Rehabilitation Center for the Blind and Vision Impaired
 VRN: Virginia Reuse Network

VSDBM-Hampton: Virginia School for the Deaf, Blind, and Multi-Disabled at Hampton
 VSDB-Staunton: Virginia School for the Deaf and the Blind at Staunton
 VSTR: Virginia Statewide Trauma Registry
 VQAS: Virginia Quality Assurance Screening (Program)
 VWC: Virginia Workforce Council

W

WCC: Workers' Compensation Commission
 WIA: *Workforce Investment Act*
 WIB: Workforce Investment Board
 WIC: Women, Infants and Children (Special Supplemental Nutrition Program)
 WIN: Work Incentive (Account)
 WIPA: Work Incentives Planning and Assistance
 WISA: Work Incentive Specialist Advocate (Program)
 WWRC: DRS Woodrow Wilson Rehabilitation Center

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