

IV. Community Living Supports

In recent decades, nationwide expansion of state-funded or -operated community services has enabled greater numbers of individuals with disabilities who need varying levels of supports to have homes in communities near their families or with other natural supports rather than reside in institutions. Thus, community services have maximized their opportunities for independence and made it possible for them to participate more fully in all aspects of community life. The national organization, United Cerebral Palsy (UCP), in its 2006 and 2007 studies of state Medicaid funding of community supports for persons with intellectual or developmental disabilities (ID/DD), emphasized that outcomes achieved by state expenditures, rather than funding amounts, should be the focus for decision-makers. UCP finds that the strength of a state's community supports for people with disabilities corresponds to the degree to which that state prioritizes its funding for inclusion. It does not correspond to the political party in leadership, the state's tax burden, or the amount of its expenditures. In its ranking of states and the District of Columbia, based on analysis of Medicaid expenditures for community supports, Virginia was 44th in support of individuals in small community residences (less than four people) and 48th in per capita family supports.

In Virginia, community living supports are provided by a diverse and complex array of public and private agencies and organizations. Most state agencies are involved, to some degree, in providing services related to community inclusion that extend throughout the lifespan and must, therefore, effectively address changing needs over time. The activities of these agencies are influenced by a variety of federal and state funding streams and regulations that have an impact [not a verb] on service eligibility, access, and availability. The number and diversity of public and private nonprofit and for-profit service providers adds to this complexity. As a result, multiple points of entry and access for services exist, with variable eligibility criteria.

Many positive initiatives are underway to improve comprehensive, integrated planning and service delivery for persons with disabilities. Major reform initiatives underway in Virginia will have an impact on the quality and scope of Medicaid-funded services and supports generally, and Medicaid Waivers specifically, during the next biennium. Virginia's two major federally funded projects, the **Money Follows the Person** demonstration initiative and the **System Transformation Grant**, working together, will expand and enrich community services under Medicaid Waivers, facilitate transition of individuals with disabilities to community residential settings of their choice, create a statewide "**No Wrong Door**" portal for services, foster person-centered practices in regulations and clinical services, improve quality assurance and monitoring of critical incidents, and otherwise improve the state's service system.

A. What Are Community Living Supports?

Community living supports are those services, programs, and activities designed to ensure that people with disabilities and their families receive the type and level of support

necessary for full integration into the community in all facets of life. They maximize opportunities for independent living, self-determination, employment, education, recreation, social interaction, and other activities. It would be impossible to include all available state-funded community living supports. Therefore, this chapter focuses on the primary support services that enable individuals with disabilities to participate effectively in all facets of community life.

Medicaid State Plan Services: Medicaid refers specifically to the federal and state jointly funded public health insurance program that provides medical and related coverage for low-income Americans and other targeted groups, including persons with disabilities, who meet eligibility requirements. The federal Centers for Medicare and Medicaid Services (CMS) require states to provide coverage for certain services under Medicaid (i.e., *mandatory services*). States may also choose to cover additional services (i.e., *optional services*). Whether mandatory or optional, federal regulations require that Medicaid-funded services must be available statewide in the same amount, duration, and scope to everyone eligible for benefits and that participating individuals must be able to choose their own providers. Each state must submit a Medicaid State Plan that describes its available mandatory and optional services to CMS for approval.

Home and Community Based (HCB) Medicaid Waivers: Medicaid Home and Community Based (HCB) Waivers give states flexibility by allowing them to “waive” any of the CMS program requirements regarding uniform amount, duration, and scope of services, particularly as a means of developing and implementing alternatives to institutionalization. For a waiver to be approved, the state Medicaid agency must assure the CMS that the annual cost to provide community-based services is no more than the cost of comparable care in an institution. This assurance can be based on either individual cost or average aggregate cost. Currently, Virginia has seven approved Home and Community Based (HCB) Waivers.

Assistive Technology and Related Services: Commonly abbreviated as “AT,” assistive technology is defined in the *Code of Virginia*, § 51.5-53, as “any item, piece of equipment, or device that enables an individual with a disability to improve his or her independence and quality of life.” The range of support provided by AT varies from simple mechanical aid to complex information technology assistance. At the state level, AT services are delivered or funded by multiple sources in diverse interconnected organizational units through a variety of individual programs described throughout this chapter.

Brain Injury and Spinal Cord Injury Services (BI/SCIS): Critical outreach services to persons with brain and spinal cord injury are provided by the Brain Injury and Spinal Cord Injury Services (BI/SCIS) unit of the Department of Rehabilitative Services (DRS). BI/SCIS manages specialized programs and services offered primarily through contractual arrangements with direct service providers. The unit also provides support, technical assistance, and training to public and private providers of brain injury services.

The **Brain Injury Discretionary Services (BIDS) Fund**, administered by DRS, offers a variety of short-term specialized services or goods for a small number of eligible individuals

each year. The Fund's goal is to support rehabilitation of persons with acquired brain injury that enables them to achieve independent living in less restrictive environments.

The **Woodrow Wilson Rehabilitation Center (WWRC)** provides outreach and direct services (residential and outpatient) for persons with brain or spinal cord injuries. Teams at WWRC work with both the individual who has sustained an injury and his or her family on treatment planning, management of personal and physical needs, vocational preparation, and independent-living skills.

Case Management: The arrangement, coordination, and monitoring of service delivery to meet the needs of children and adults with disabilities and their families are provided by a variety of resources. Case management services for persons receiving publicly funded mental health, intellectual disability (mental retardation), and substance abuse services are provided by 37 **Community Services Boards (CSBs)** and 3 **Behavioral Health Authorities**, hereafter referred to as **CSBs**. Some individuals who receive Medicaid-funded services through **Home and Community Based Medicaid (HCB) Waiver** programs may receive similar case management services for the development, coordination, implementation, monitoring, and modification of their service plans. Not all HCB Waivers, however, cover case management services.

Certain case management services are also provided through programs administered by the Department of Rehabilitative Services (DRS) and the Department of Medical Assistance Services (DMAS). DRS's **Community Rehabilitation Case Management Services** (created in the *Code of Virginia*, § 51.5-9.2, as the Long Term Rehabilitative Case Management Program) serves individuals with long-term functional or central nervous system disabilities. Case management services for older Virginians participating in a **Program for All-Inclusive Care for the Elderly (PACE)** are funded by DMAS.

Comprehensive Services Act (CSA): As defined in *Code of Virginia*, § 2.2-5200 et seq., the goal of CSA 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 youths and their families." CSA was enacted to address problems associated with the fragmented service system including service duplication across multiple state agencies, unequal access to care statewide, reliance on more expensive treatment services, and significant annual growth in expenditures. A pooled funding stream (eight categorical funding streams across four agencies) has been a critical and unique feature of CSA since its inception.

CSA objectives are intended to ensure that services are consistent with state policies for family preservation and for treatment in the least restrictive environment, intervene early with youths who are at risk of developing emotional or behavioral problems and their families, and increase family involvement in service delivery and management. CSA encourages public-private partnerships and interagency collaboration in the design and delivery of services that are responsive to the unique strengths and needs of troubled youths and their families.

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 self-reliance. Although a variety of public and private entities, including Employment Service Organizations, offer similar services, the primary providers of these services in Virginia are regional **Centers for Independent Living (CILs)** and the Department for the Blind and Vision Impaired's (DBVI) **Rehabilitation Teaching/Independent Living (RT/IL) Program**.

Authorized under the Rehabilitation Act of 1973, as amended, (P.L. 93-112) and under the *Code of Virginia*, § 51.5-23-25, the Center for Independent Living (CIL) Program provides funding for community-based, cross-disability, nonresidential agencies controlled by individuals with disabilities. Sixteen CILs and four Satellite CILs, spread across 18 of Virginia's 23 planning districts, work directly with individuals to develop and support self-advocacy, provide resource information and referrals, provide training, promote high-quality services, and provide services to communities, thereby removing barriers to independent living. Specifically targeting blindness and related visual or sensory impairments, DBVI RT/IL also provides services that enable individuals to maximize their economic, social, and personal independence and participation in community life.

Omnibus Budget Reconciliation Act (OBRA): Under the federal Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203), states are required to evaluate persons with intellectual disabilities (mental retardation) or related conditions to determine whether the individual requires the level of services provided in Medicaid-funded nursing facilities and, for those admitted, to determine annually the specialized services needed to maximize their self-determination and independence as well as their continued need for nursing facility care. When a nursing facility resident is determined either no longer to need that level of care or chooses community-based services, the state must begin discharge, including resident preparation and arrangements for or provision of community services. States are also required to provide or arrange for delivery of those specialized services when they are not available through the nursing facility or are not covered under the Medicaid State Plan. In Virginia, OBRA requirements are fulfilled through collaboration between the Departments of Medical Assistance Services, Rehabilitative Services, and Mental Health, Mental Retardation and Substance Abuse Services.

Outreach, Training, and Technical Assistance: All of the state's disability services agencies, as well as numerous public and private organizations statewide, provide outreach, training, and technical assistance supporting community living. These initiatives are generally designed to address the specific needs of the agency's or organization's constituency and may be disability specific. A description of all available training programs is beyond the scope of this report. A few key programs are described, however, including programs that provide critical communications access for the deaf, hard of hearing, deafblind, and persons with speech impairments. These include both the **Virginia Relay** and **Interpreter Services Program**, administered by the Virginia Department for the Deaf and Hard of Hearing (DDHH).

Personal Assistance Services (Non-Waiver): Individuals with physical disabilities such as spinal cord injuries, cerebral palsy, or muscular dystrophy who require assistance from another

person to perform nonmedical activities of daily living and who are not eligible for these services under any other program may qualify for Personal Assistance Services (PAS) provided by the **Department of Rehabilitative Services (DRS)**. With support from state general funds, DRS offers PAS to individuals who are not receiving vocational rehabilitation services through two programs, **PAS for Individuals with Brain Injury** and **State-Funded PAS** (consumer directed). In addition, both DRS and the **Department for the Blind and Vision Impaired (DBVI)** offer PAS specifically for vocational rehabilitation (VR) service recipients.

Publicly Funded Mental Retardation Services: The **Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS)** is the state agency responsible for planning, monitoring, and overseeing publicly funded services for persons with intellectual disabilities (mental retardation) living in the community or in the state's Training Centers. (See the Institutional Supports chapter of this report for more information on the latter.) DMHMRSAS contracts with 37 independent, local **Community Services Boards** and 3 **Behavioral Health Authorities** (hereafter referred to as CSBs) that are designated by *Code of Virginia*, § 37.2-500 and § 37.2-601, as the single point of entry into the state's mental health, mental retardation, and substance abuse services system. The CSBs provide or contract for a variety of services for persons who have intellectual disabilities (mental retardation), mental illness, or substance abuse problems.

Services for Virginians Who Are Elderly: While many state agencies provide services across the lifespan, the Virginia Department for the Aging and two key programs, administered by other agencies, specifically target older Virginians. Unless otherwise indicated, these services are available to all elderly citizens, not just those with disabilities.

The **Virginia Department for the Aging (VDA)** is legally designated as the agency responsible for oversight of all Virginia programs funded through the federal Older Americans Act, Amended 2006 (P.L. 109-365), as well as those funded by state appropriations approved by the General Assembly. VDA's role is primarily to ensure services are available statewide, to develop and monitor service standards, and to be both an educational and outreach resource and a central referral agency for direct services provided by 25 local **Area Agencies on Aging (AAAs)**. VDA also works to protect the rights of citizens of all ages who are indigent and incapacitated by administering the **Virginia Public Guardianship and Conservator Program**.

The **Program for All-Inclusive Care for the Elderly (PACE)** is a Medicaid State Plan optional service funded by the **Department of Medical Assistance Services (DMAS)**. This program is designed to provide more effectively services that will enable Virginians age 55 years or older to stay in home- and community-based settings and avoid more costly and more restrictive institutional placement. The program seeks to assist individuals in maintaining their independence, the highest level of functional abilities, and self-sufficiency.

The **Department for the Blind and Vision Impaired (DBVI)** serves Virginians ages 55 and older who are experiencing visual impairment through its **Older Blind Grant Program**. The goal of this program is to enable individuals to gain and maintain independence within their home and community as well as maintain maximum self-direction.

Service System Planning: In addition to the above direct sources of services and funding, two additional entities provide advice and assistance for Virginia's system of community living supports.

Disability Services Boards (DSBs), authorized by *Code of Virginia*, § 51.5-47- 48, in 1992, assist localities in identifying and addressing the needs of persons in their communities with physical and sensory disabilities. DSBs are charged with advising state and local governments on the needs of their communities and with managing the **Rehabilitative Services Incentive Fund**, which provides limited funding to leverage additional public and private resources to improve service delivery. Membership of the 40 DSBs includes representatives of local government, business and industry, and the community at large. The composition of each DSB is unique, but 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 local mix of public and private resources and local needs.

The **Statewide Independent Living Council (SILC)**, created under the *Code of Virginia*, § 51.5-25.1, is charged with planning for independent living services through the development of a three-year State Plan for Independent Living and works with the Department of Rehabilitative Services and Department for the Blind and Vision Impaired at the state level toward that end. As an independent planning and advocacy body, the SILC's members are appointed by the governor to be representative of persons with significant disabilities from across the state, Centers for Independent Living (CILs), and other recipients and providers of independent living services. The SILC's mission is to promote effective policies, programs, and activities that maximize independence for Virginians with disabilities. The goals of the SILC include empowerment of individuals with disabilities, youth advocacy, assisting current CILs in service to unserved and underserved populations, continued improvement of community-based services, promotion of independence and self-sufficiency for people with disabilities, and provision of a comprehensive array of independent living services throughout the Commonwealth.

B. Who Is Eligible for Community Living Supports?

Medicaid State Plan Services: Medicaid and related publicly funded health insurance programs are critical to Virginia's system of community living supports for persons with limited resources. Medicaid funds long-term care for individuals who are elderly or who have disabilities, and supplements coverage for persons who are older than age 65 or otherwise eligible for Medicare, another federal health insurance program. For parents of minor children with disabilities, parental income and other financial resources are considered in determining the child's eligibility, but consideration is also given to the impact on the family of exceptionally high medical bills. In July 2006, federal law mandated a new eligibility requirement, verification of both citizenship and identity for all Medicaid applicants and current recipients, except those who receive Medicare or Supplemental Security Income (SSI). Information on the types of

documentation acceptable is available at the Department of Medical Assistance Services (DMAS) Web site.

Under state statute (§ 32.1-325.2), Medicaid is a “payor of last resort.” When an individual also has third-party private insurance, the private insurer first must pay for any services covered under the policy. More information on Medicaid and public insurance programs can be found in the Health chapter of this report. Detailed, current information on financial eligibility requirements can be obtained from the state Department of Social Services (DSS), which, in Virginia, determines whether applicants are eligible for Medicaid coverage.

Home and Community Based (HCB) Waivers: To receive services through a HCB Waiver, an individual must meet the eligibility criteria for the specific waiver for which he or she is applying, meet the long-term care criteria through a formal clinical assessment, and undergo an assessment of financial need. An individual’s total income for eligibility is limited to no more than 300 percent of the Supplemental Security (SSI) payment limit (in 2007, \$ 1,869 per month) and a \$2,000 resource limit. Parental income and resources are not considered in determining eligibility for minor children, however. Three of the seven current HCB Waivers (Elderly or Disabled with Consumer Direction, Technology Assistance, and HIV/AIDS) allow a “spend-down” related to income and the cost of medical expenditures for eligibility. HCB Waivers do not require per-service “co-payments” 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. Specific eligibility criteria for each HCB Waiver follow.

Eligibility for the **Mental Retardation (MR) Waiver** requires a diagnosis by a licensed professional of intellectual disability (mental retardation) 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 Mentally Retardation (ICF-MR). The eligibility determination requires a formal, standardized assessment of the person’s current level of cognitive functioning. The individual or family must also declare that services would be accepted within 30 days of being offered.

Because there are insufficient MR Waiver slots to meet demand, additional criteria are used to prioritize funding for services through Waiting Lists. Waiting lists are maintained through a partnership between the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) and local Community Services Boards (CSBs).

Individuals are assessed on urgency of need and are assigned to one of two Waiting List categories, Urgent or Non-Urgent, or to a local Planning List. Individuals on the Non-Urgent Waiting List are only served after all individuals on the Urgent List have been served. Local CSBs make the determination of whether an individual is assigned to the Urgent or the Non-Urgent List. Once that determination is made, the individual’s Waiting List “slot” moves with him or her should the individual relocate within Virginia. The Planning List, also maintained by CSBs, is not considered to be an official part of the statewide Waiting List. Individuals on the Planning list generally qualify for the MR Waiver but do not meet the requirement of accepting services in 30 days.

Eligibility for the Urgent Waiting List for the MR Waiver requires that an individual meet at least one of seven additional criteria:

1. The primary caregiver (or caregivers) is age 55 or older;
2. The individual is living with a primary caregiver who is providing the service voluntarily and without pay and cannot continue to do so;
3. There is a clear risk of abuse, neglect, or exploitation;
4. The primary caregiver has a chronic or long-term physical or psychiatric condition significantly limiting his or her ability to provide care;
5. The individual is “aging out” of a publicly funded residential facility or otherwise in danger of becoming homeless;
6. The individual 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 of either:
 - a. 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
 - b. the individual’s physical or medical needs are not being managed by the primary caregiver even with supports arranged for or provided by the CSB.

Individuals residing in community ICFs-MR or nursing homes are not eligible to be assigned to the Urgent Waiting List because their health, safety, and welfare needs are being met in the institution. MR Waiver slots, however, have been specifically allotted in recent years to Training Center residents to facilitate discharge.

The **Day Support Waiver**, which became effective in July 2005, is limited to individuals currently on either the Urgent or Non-Urgent Waiting Lists for the MR Waiver. A person receiving services under the Day Support Waiver may remain on the MR Waiver Waiting List until a slot becomes available and is assigned to him or her. The Day Support Waiver currently has a state budget allocation for 300 slots.

The **Individual and Family Developmental Disabilities (DD) Waiver** is targeted to individuals age 6 years or older who do not have a diagnosis of intellectual disabilities (mental retardation) but who have a developmental disability (“related condition”). To be eligible for the DD Waiver, an individual must meet the level of care criteria for services in an ICF-MR, and it must be shown that the community-based waiver services are critical to enabling the individual to remain at home rather than being served in an ICF-MR. Diagnostic, functional, and financial criteria are all considered in determining eligibility.

The number of slots available for participation in the DD Waiver, like any other waiver, is subject to funding limitations. The DD Waiver has a single statewide Waiting List, and slots are assigned from that list on a “first-come, first-served” basis. Ten percent of Level 1 DD Waiver slots (which comprise 50 percent of total DD Waiver slots) are designated to provide

“emergency” slots without consideration of the length of time on the Waiting List. To be eligible, an individual must meet at least one of four emergency criteria:

1. The primary caregiver has a serious illness, has been hospitalized, or has died;
2. The individual has behaviors that present a risk to personal or public safety;
3. The Department of Social Services (DSS) has determined that the person has been abused and is in need of immediate waiver services; or
4. 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 seeking services under the **Elderly or Disabled with Consumer Direction (EDCD) Waiver** must be age 65 or older or, regardless of age, have a disability (including cognitive impairment), and meet criteria for nursing facility level of services. An evaluation is conducted by a Preadmission Screening Team, using a standardized questionnaire, the **Uniform Assessment Instrument (UAI)**, to determine medical and functional capacity needs. Patient-pay may be required if the individual’s income exceeds the Social Security Income limit. Individuals may receive EDCD services while on the Waiting Lists for either the MR or DD Waivers.

Individuals who need both a medical device to compensate for the loss of a vital body function and who require substantial ongoing skilled nursing care may be eligible for the **Technology Assisted (Tech) Waiver**. To determine eligibility, a screening team from the local department of social services must complete the UAI, with subsequent follow-up screening by the Department of Medical Assistance Services (DMAS). To qualify, an adult must, be dependent for at least part of the day on a ventilator or meet complex tracheotomy criteria. For youth younger than 21, the DMAS staff screens to determine whether the child has the same dependencies as those already listed for adults or has a daily dependence on some other device-based respiratory or nutritional support. Cost effectiveness of technology services for adults is compared to specialized care in a nursing facility; and for youths, the comparison is to a long-stay hospital. Financial eligibility determination does not consider parental income and resources for children younger than age 18. Adults may have a patient pay for services based on income.

To be eligible for the **HIV/AIDS Waiver**, individuals must be diagnosed with the human immunodeficiency virus (HIV) or acquired immune deficiency syndrome (AIDS) and must have documented medical or functional symptoms associated with AIDS that would require care in a nursing facility or hospital. Basic Medicaid State Plan eligibility requirements and the income limit stated earlier apply. There is no patient-pay requirement.

The Alzheimer’s Assisted Living Waiver (AAL, or Alzheimer’s Waiver) requires that an individual meet financial criteria as well as the following: be elderly or disabled as defined by section 1614 of the Social Security Act; meet level of care for nursing facility placement; be diagnosed with Alzheimer’s disease or a related dementia by a licensed clinical psychologist or

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. Individuals who have a diagnosis of mental retardation (intellectual disability) are **not** eligible for this waiver.

Assistive Technology (AT) and Related Services: The Department of Rehabilitative Services's (DRS) **Virginia Assistive Technology System (VATS)**, which receives federal funding from the U.S. Department of Education's Rehabilitative Services Administration, is responsible for assisting Virginians with disabilities in gaining access to and acquiring assistive technology devices and services. There are no eligibility criteria for receipt of assistance.

In addition to VATS, DRS's **Woodrow Wilson Rehabilitation Center (WWRC)** offers AT services to individuals across the Commonwealth, with an emphasis on developing work and independent living skills. Many individuals receiving services at WWRC are vocational rehabilitation clients, and each WWRC program has its own specific eligibility requirements.

The **Technology Assistance Program (TAP)**, administered by the Virginia Department for the Deaf and Hard of Hearing (DDHH), provides AT services and devices for Virginia residents who are deaf, hard of hearing, deafblind, otherwise hearing as well as vision impaired, or have speech impairments. The 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. Proof of residency is also required. A complete application form must be submitted. 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 two 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.

Additional AT services, equipment, and funding are provided through local school divisions, vocational rehabilitation agencies, Omnibus Budget Reconciliation Act (OBRA) activities, the Medicaid State Plan, Home and Community Based Waivers, and other state and local programs. The services provided and eligibilities for each of these are unique and too diverse and numerous to be covered here. For details, the administering authority for each program should be consulted directly.

Currently undergoing a name change to the **NewWell Fund** (to take effect on July 1, 2008, subject to General Assembly approval), the **Assistive Technology Loan Fund Authority (ATLFA)** assists Virginians in securing low interest loans to obtain AT and related services. Generally, any individual with a disability or family member of that individual, regardless of income, is eligible for ATLFA (NewWell Fund) assistance. Prospective borrowers must demonstrate their creditworthiness and repayment abilities to the satisfaction of the ATLFA (NewWell Fund) Board. In considering applications, the ATLFA (NewWell Fund), unlike other lenders, can overlook credit issues related to the person's disability. Additional eligibility criteria, however, exist for Telework Loans, which provide financing for equipment or home

modifications to enable employment. Information on Telework Loans can be obtained through the ATLFA (NewWell Fund).

Small businesses and nonprofit organizations may also receive ATLFA- (NewWell Fund) facilitated loans if they can demonstrate that the AT equipment will be used either to employ or to retain one or more persons with a disability or to make structural modifications consistent with the Americans with Disabilities Act (ADA) for the benefit of people with disabilities.

Prior to the program's elimination caused by state budget cuts in the fall of 2007, individuals with disabilities who could not find funding for goods and services, primarily AT, through any other source could also apply for access to DRS's **Consumer Services Fund**, administered by the ATLFA (NewWell Fund).

Brain Injury and Spinal Cord Injury Services: The Department of Rehabilitative Services's (DRS) **Woodrow Wilson Rehabilitation Center (WWRC) Brain Injury Services Department and Spinal Cord Injury Services (BI/SCIS)** program determines eligibility for and provides services to persons with these disabilities, respectively, and access to and delivery of services are subject to differing policies for each program. Brain and spinal cord injuries with onset prior to age 22 that result in substantial functional limitations and ongoing needs are considered developmental disabilities.

The WWRC Brain Injury Services Department serves individuals with acquired brain injury, both traumatic and nontraumatic. The individual must be "medically, physically and psychologically stable with a favorable prognosis of participating in, completing, and benefiting from the services," and current behavior must be deemed not likely to "jeopardize the health, safety, or rehabilitation program" of the individual or others. Applicants with a co-occurring psychiatric diagnosis or a history of substance abuse must be able to demonstrate six consecutive months of stability. To be admitted for WWRC Brain Injury Services, persons must either be referred by a DRS counselor or make a direct application (available on the WWRC Web site). In addition, the individual must complete a two-to-three-day feasibility evaluation at WWRC to determine whether admission is appropriate and what services are needed.

Individuals eligible for WWRC Spinal Cord Injury Services (SCIS) must be at least 15 years of age and medically stable. For each program, DRS clients pursuing vocational goals are given priority.

To be eligible for assistance through the **Brain Injury Discretionary Services (BIDS) Fund**, administered by DRS BI/SCIS, an individual must submit an application. BIDS staff members review all applications, "consider information from the referral source, the individual who will be receiving services, and his or her family/support person(s)," and determine whether to fund the specific services recommended. Individuals must have a documented acquired brain injury, be at least one year postinjury, 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 (e.g., Medicaid or private insurance or DRS), 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. Because of limited BIDS Fund resources, the staff encourages individuals to contact BI/SCIS to verify funding availability and eligibility prior to submitting an application.

Case Management: Case management from local **Community Services Boards (CSBs)** is available to all persons who have intellectual disabilities (mental retardation), or who have a co-occurring intellectual disability and another disability, and who are receiving or are eligible for publicly funded mental health, mental retardation, and substance abuse services. These services may require payment on a sliding scale depending on local CSB policies.

Individuals eligible for the **Mental Retardation (MR), Day Support, Developmental Disabilities (DD), Tech, and AIDS Medicaid Waivers** are also eligible for case management services as soon as they have been determined to be eligible for those waivers, regardless of whether they have obtained an actual waiver “slot.” The Elderly or Disabled with Consumer Direction (EDCD) Waiver does not include coverage of case management services unless the individual is elderly or has been determined to be eligible for the MR or DD Waiver and has been placed on the waiting list for either waiver while receiving services under the EDCD Waiver. Case management services for the elderly under the EDCD Waiver are limited both in the length of time provided and to certain geographic areas of the state.

The Department of Rehabilitative Services’s (DRS) **Community Rehabilitation Case Management (CRCM) Services** program provides case management for persons who have a physical or sensory disability, require a special combination of services for lifelong or extended duration, and experience substantial limitations in three or more life areas. Because of limited resources, CRCM services have additional eligibility criteria, which establish access priorities:

- Priority I: The individual is in danger of being placed in a psychiatric facility, nursing facility, or other institutional setting or has been accepted for services through the DRS Brain Injury Discretionary Services (BIDS) Fund.
- Priority II: The individual lacks an existing support service system and is not receiving service coordination from any other agency or organization.
- Priority III: The individual has been identified as needing case management in order to improve overall quality of life and access to services.
- Priority IV is the date of application for individuals meeting program eligibility.

In addition to these priorities, preferential access to CRCM services is given to public safety officers and military veterans disabled in the line of duty.

Comprehensive Services Act (CSA): Because multiple federal mandates must be met, various eligibility criteria exist for CSA services. Eligible youths must be either younger than age 18 or 22, depending on the service, and they must be eligible for mandated services such as special education or foster care. *Code of Virginia*, § 2.2-5211, identifies five populations for CSA state

pool funds. Each population, listed below, reflects youths who would have been served by one of the eight funding streams pooled into CSA:

1. Children receiving services for purposes of special education in approved private school education programs;
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 *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 the Department of Juvenile Justice and placed by that agency into a private home or public or private facility with approval from the local Community Policy and Management Team (CPMT) and Family Assessment and Planning Team (FAPT).

The State *Code* further identifies children in the first three categories above as “mandatory” populations, that is, both the state and localities are mandated to provide sufficient funding for the special education and foster care services for those youths.

To receive services, a child or adolescent (mandated or nonmandated) must also meet one or more of the criteria listed below:

1. Have significant, persistent emotional or behavioral problems;
2. Be either in, or is at imminent risk of entering, purchased residential care or other resources beyond normal agency and collaborative interagency services;
3. Require services for purposes of special education in approved private school educational programs; or
4. Have been placed in foster care through a parental agreement with a local social service agency, entrusted by parents or guardian to a local social service agency, or committed to the agency by the court.

In all cases, to be eligible for CSA, the services required to meet the child’s needs must be beyond normal agency resources or beyond routine collaborative processes across agencies and require coordinated interventions by at least two agencies.

Based on the availability of additional public funds, localities may choose to designate a certain amount of CSA funds to serve other, nonmandated children with emotional or behavioral problems, particularly those needing services from multiple agencies. There is no legal requirement, however, that local governments provide the matching funds to do so.

Concerns being raised that some localities have required parents to relinquish custody of their child in order to receive CSA services led to requests for clarification regarding CSA mandates for mental health services. In December 2006, Virginia's Attorney General issued an advisory opinion that foster care services, as defined by *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 statute defines a "child in need of services" as being "a child whose behavior, conduct, or condition presents or results in a serious threat to the well-being and physical safety of the child" or of another person if the child is younger than the age of 14. This opinion further stated that statutory and constitutional provisions require that CSA services be provided to eligible children without requiring parents to relinquish custody. In November 2007, the governing body of CSA, the State Executive Council, finalized interagency guidelines for determining eligibility and serving these children and their families.

Independent Living and Related Services: Under the federal Rehabilitation Act of 1973, as amended, anyone with a significant disability is eligible for services from a local **Center for Independent Living (CIL)**. In that act, someone with a significant disability is defined as an individual with a severe 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 act further specifies that services should be provided when they will improve that individual's ability to function, continue functioning, or move toward functioning independently in the family or community or improve his or her ability to continue in employment.

Statewide, the **Department for the Blind and Vision Impaired (DBVI)** provides and funds services addressing the needs of the more than 112,000 Virginians of all ages who are blind, deafblind, or have other significant vision impairments through its **Rehabilitation Teaching/Independent Living Services (RT/ILS)** programs. Eligibility for RT/IL services requires verification of the individual's 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. There are no age restrictions. Once a person has met the basic eligibility for RT/IL services, he or she can be referred to other programs such as Deafblind or Low Vision Services based on needs identified by the Rehabilitation Teacher through a functional assessment. Financial eligibility requirements, based on a formula intended to identify consumers with the greatest economic need, exist for the purchase of some equipment. Individuals determined financially eligible can receive RT/IL tangible goods and purchased services at no cost to themselves or their families. Those declared financially ineligible may be required to pay some or all of the costs for certain tangible goods and purchased services. Financial eligibility criteria are updated annually.

Personal Assistance Services (Non-Waiver): Both Home and Community Based (HCB) Medicaid Waivers, for which eligibility and specific services are described elsewhere in this chapter, and Department of Rehabilitative Services (DRS) Vocational Rehabilitation (VR) programs provide personal assistance services (PAS). More-detailed information on VR eligibility requirements and services can be found in the Employment chapter of this report.

State-Funded PAS and PAS for Individuals with Brain Injury, administered by DRS, are available on a limited basis to individuals who are in need of services but do not qualify for comparable services from any other source. An individual must complete and submit an application for services, after which an assessment is made to determine service needs and to ascertain whether comparable services can be obtained from any other source (such as VR PAS, Medicaid Waivers, the brain injury program, or others).

Publicly Funded Mental Retardation Services: Persons with a diagnosis of intellectual disability (mental retardation), mental illness, or substance abuse are eligible for services coordinated and often provided by local **Community Services Boards (CSBs)**. Persons with developmental disabilities who do not have a concurrent diagnosis of intellectual disability are not eligible for CSB services unless a locality has chosen to offer services to them and has the resources to do so.

Omnibus Budget Reconciliation Act (OBRA): The Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) is responsible for evaluating persons with intellectual disabilities (mental retardation) or related conditions residing in Medicaid-funded facilities, determining their specialized service needs, and then providing or arranging for the 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 intellectual or developmental disabilities eligible for services under OBRA must have a significant disability that was evident before age 22. In addition, a determination must be made that these individuals need and can benefit from specialized services. Identification of individuals takes place through the Nursing Home Pre-Admission screening prior to admission to a Medicaid-funded nursing facility. Further identification can occur when an individual experiences a significant change of condition and participates in a Resident Review.

Services for Virginians Who Are Elderly: Services targeted to Virginia's older population are coordinated and provided by the Virginia Department for the Aging (VDA) in contractual partnership with local **Area Agencies on Aging (AAAs)**. All older Virginians are eligible to receive information, referrals, and technical assistance from these agencies, with the services offered by local AAAs specifically tailored to their communities' needs. Some AAA services, however, are provided on a sliding fee scale based on ability to pay.

VDA also manages the **Public Guardianship and Conservator Program** that funds local human service agencies providing public guardianship services not just for the elderly, but also for persons of any age who are determined to be "incapacitated" (i.e., unable to care for

themselves or make decisions about their care), 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 to all individuals needing them.

A listing of all other agencies providing services specifically for older Virginians is beyond the scope of this report, but eligibility for two key programs providing funding are noted below.

Virginia residents older than the age of 55 who have a documented visual impairment that significantly interferes with normal life activities and who meet financial qualifications are eligible for assistance from the federally funded **Older Blind Grant Program** administered by the Department for the Blind and Vision Impaired (DBVI).

State regulations (12VAC30-120-63), effective July 1, 2007, specify that individuals eligible for the **Program for All-Inclusive Care for the Elderly (PACE)** must “be 55 years or older; be nursing home eligible...; and reside in the service area of the PACE organization.” In addition, their income must be equal to or less than 300 percent of the current 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 the Department of Medical Assistance Services (DMAS) conducts a formal evaluation of an individual using the Uniform Assessment Instrument, a standardized questionnaire, in compliance with the *Code of Virginia*, § 32.1-330.

C. How Are Community Living Supports Accessed and Delivered?

Medicaid State Plan Services: Long-term care services under the Medicaid State Plan are accessed and delivered through a broad array of private, nonprofit, and public service providers. Individuals must apply for and be found eligible to receive Medicaid benefits and must follow guidelines for accessing services set forth by the **Department of Medical Assistance Services (DMAS)**.

Medicaid Home and Community Based (HCB) Waivers: Although certain processes are shared between them, access to and screening for each of the Medicaid HCB Waivers is unique. The Departments of Health (VDH) and Social Services (DSS) conduct screenings for the Elderly or Disabled with Consumer Direction (EDCD) Waiver, HIV/AIDS Waiver, and Alzheimer’s Assisted Living Waiver. VDH and DSS staff members also screen adults for the Technology Assisted (Tech) Waiver. The Department of Medical Assistance Services (DMAS) screens children and adolescents for the Tech Waiver. Community Services Boards (CSBs) perform screenings for the Mental Retardation (MR) Waiver and the Day Support Waiver. Local health (Child Development) clinics screen applicants for the Individual and Families Developmental Disabilities (DD) Waiver.

To gain access to MR, DD, and Day Support Waiver services, a **Level of Functioning Survey** must be completed to determine that the level of care needed matches criteria for alternative placement in an Intermediate Care Facility for Mental Retardation (ICF-MR). For access to the AIDS, EDCD, and Tech Waivers, the **Uniform Assessment Instrument (UAI)** is completed. This instrument assesses social, physical, health, and other functional criteria for nursing facility placement (the alternate institutional placement).

In addition to these two instruments, access to the EDCD Waiver and the Alzheimer's (AAL) Waiver may require additional assessments. For the **EDCD Waiver**, completion of a **Supplemental Screening** may be required. The supplement is initiated by the nursing facility preadmission screening team for individuals who have mental illness, intellectual disability (mental retardation), or related conditions to determine whether they have active treatment needs that cannot be met by a nursing facility or through nursing-related Waivers. Access to the **Alzheimer's (AAL) Waiver** requires that the staff in the local department of social services determines eligibility for an Auxiliary Grant, which is a cash assistance program for recipients of Supplemental Security Income (SSI) and certain other aged, blind, or disabled individuals who either reside in or are seeking to reside in an assisted-living facility. Once a determination is made that all criteria have been met, a list of providers is offered to the recipient and his or her family for choice of placement.

Although a person may be found eligible for a Home and Community Based Medicaid Waiver, access to services may be limited by waiting lists because of inadequate funding. For the **MR Waiver**, the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) reports that the CSB staff members routinely review their active cases to identify individuals who are receiving services that may have become insufficient to meet current needs and who may be eligible for MR Waiver services.

Both the time individuals spend on the MR Waiver Waiting List and the number of individuals on other MR services waiting lists maintained by CSBs are significant. The *DMHMRSAS Comprehensive State Plan for 2008–2014* reports that since July 2004, despite allocation of more than 1,354 slots, the number of persons on the MR Waiver “Urgent” Waiting List has grown by more than one individual per day. According to the DMHMRSAS 2007 legislative *Study of the Mental Retardation Service System in Virginia*, while the average wait time for the MR Waiver was 28 months, it was significantly longer (from 3 to 7 years) for those on the Non-Urgent Wait List.

Between state Fiscal Years 2005 and 2007, according to data from the Department of Medical Assistance Services, the number of persons served under the MR Waiver increased by 429 (6.7 percent), from 6,421 to 6,850. In addition, the DMHMRSAS reported that a total of 3,872 were on the MR Waiver Waiting List on June 30, 2007. Of those, 2,017 were on the Urgent List; and 1,855, on the Non-Urgent List. (Waiting List data for 2005 are not available.) No new MR Waiver slots were added in July 2005, but an additional 145 new slots were added for persons living in communities in FY 2006.

The length of time spent on the MR Waiver Waiting List appears below. These data include all persons determined to be eligible for the MR Waiver and assigned to either the Urgent or Non-Urgent Waiting List as of December 18, 2007. The length of time reflects the period from inclusion on the Waiting List until the start of actual access to waiver services. The counts on this and subsequent tables do not include individuals who had requested waivers but were still awaiting a determination of eligibility. They similarly do not include individuals who might be eligible for waiver services but are not aware of them or have not applied for them and, therefore, may underestimate total need and demand.

LENGTH OF TIME ON WAITING LISTS FOR MR WAIVER

<u>Length of Time</u>	<u>Number of Persons</u>
Less than 1 year	1,009
1 year	757
2 years	646
3 years	460
4 years	384
5 years	152
6 years	112
<u>7 years or longer</u>	<u>138</u>
<u>TOTAL</u>	<u>3,658</u>

Source: Office of Mental Retardation, DMHMRSAS, January 2008

Data is point-in-time as of December 18, 2007.

The duration of an individual's wait for the MR Waiver at that point-in-time varied by less than three months according to his or her priority. The average length of time for individuals on the Urgent Waiting List was 873 days, or 2.4 years; and on the Non-Urgent Waiting List, 949 days, or 2.6 years. Duration of the wait time, however, is influenced by the availability of funding for new waiver slots as well as changes in the number of persons needing services each year, and thus fluctuates over time.

The following table depicts the number of persons who received a **DD Waiver** or were on the DD Waiver Waiting List at the end of Fiscal Years (FY) 2005 and 2007. For individuals on the waiting lists, DMAS also maintains cost data on the level of services identified in individual plans. Level 1 plans are those estimated to cost less than \$25,000 per year; Level 2, more than \$25,000 per year.

PERSONS RECEIVING OR ON WAITING LIST FOR DD WAIVER

	FY 2005	FY 2007	Change
Number Receiving Waiver	338	589	251 / 74%
Number on Waiting List	284	594	310 / 109%
Level 1 Needs	161	246	85 / 53%
Level 2 Needs	123	348	225 / 183%

Source: Department of Medical Assistance Services, as of June 30 of each year.

As the data indicate, although the number of persons receiving DD Waiver services increased significantly (74 percent) between Fiscal Years 2005 and 2007, the number of persons on the Waiting List more than doubled. The majority of the waiting list increase was for individuals with Level 2 plans, whose numbers almost tripled during this period.

Individuals on either the MR Urgent or Non-Urgent Waiting Lists gain access to the **Day Support Waiver** according to the “date of request,” defined as the date on which the individual, or an authorized representative acting on his or her behalf, first requested mental retardation services. The date of request may be either the day when eligibility screening was requested or when an application for services was made. According to the Department of Medical Assistance Services, 265 persons were served under the Day Support Waiver in FY 2007.

Under the **EDCD Waiver**, there is no waiting list at this time. Eligible individuals can immediately obtain services. In Fiscal Year 2005, 11,901 individuals received services under the EDCD Waiver. During FY 2006, this waiver supported services for 12,588 individuals, and during FY 2007, for 13,965 individuals, an increase of 1,377 (10.9 percent).

The **Tech and HIV/AIDS Waivers** also do not have waiting lists. In Fiscal Year (FY) 2005, 363 people were served by the Tech Waiver; in 2007, 384. In FY 2005, 213 individuals received services through the HIV/AIDS Waiver; in FY 2007, 384.

Funding for the new **Alzheimer’s Waiver** supports a maximum of 200 individuals annually. This waiver does not have a waiting list. Although implementation began in September 2005, growth of the program has been slow because of the need for outreach to potential providers and delays in the provider enrollment process. As a result, only 18 individuals received services under this waiver in FY 2007.

Once eligibility has been determined for any of the HCB Waivers, delivery and management of services becomes more divergent. Individuals receiving AIDS or Tech Waiver services choose an agency that will work with them to develop an individual service **Plan of Care**. Service recipients under the EDCD Waiver are not eligible for case management unless they are elderly or are on the MR or DD Waiver Waiting Lists, and case management services for the elderly are limited to certain geographic areas and in the length of time they may be provided. As a result, a Plan of Care is developed for those individuals by each agency or other entity providing services under the waiver, and an individual may have multiple Plans of Care.

Under the MR, Day Support, and DD Waivers, a **Consumer Service Plan**, similar to the Plans of Care for the other waivers, is developed by the case manager and the individual, as well as his or her family, when appropriate. Together, they determine the preferred and necessary supports. The Consumer Service Plan and related forms for the DD Waiver are consistent statewide, describe the services that will be provided, and include all supporting documentation. The individual and family select the specific providers for needed services. Under the DD waiver, the same organization cannot provide both case management and other direct services to an individual. Under the MR waiver, the provider of case management (the CSB or its contracted entity) may also provide direct services to an individual.

The concept and practice of **consumer direction** refers to situations in which the individual with a disability who is receiving services, the “consumer,” is responsible for deciding how and when those services will be provided, who will provide them, and when they will be provided. As an important component of effective community integration of persons with disabilities, consumer direction enables individuals, and their families or guardians where appropriate, to retain freedom of choice and control.

In Virginia, the DD Waiver has included consumer direction for personal care, respite, and (for adults) companion services since its inception in 2000. Consumer direction of personal assistance, respite, and companion services was extended to the MR Waiver in 2001. Consumer-directed personal assistance and respite services were included in the HIV/AIDS Waiver in 2003 and in the EDCD Waiver when it was created in 2005. Pending federal Centers for Medicare and Medicaid Services’ (CMS) approval and regulatory authorization, consumer-directed services will be available under the Day Support Waiver in 2008. Consumer-directed services are not currently available under the Alzheimer’s or Tech Waivers.

As a recipient of consumer-directed services, the individual with a disability is the employer of record with the federal Internal Revenue Service (IRS). **Service Facilitators**, who are selected by the individual with a disability from a variety of sources, prepare documentation of the need for services based on information provided by the person, monitor the delivery of services, and otherwise support individuals with disabilities who function as managers of their own staff. If desired by the person who has a disability, facilitators may also 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 attendants, companion aides, and respite workers on behalf of individual receiving services.

For nonconsumer-directed services, a variety of governmental, nonprofit, and for-profit organizations provide services to HCB Waiver recipients. Specific requirements (such as professional licenses for staff members or agency licensure by the Department of Mental Health, Mental Retardation and Substance Abuse Services or other state departments) may be required for certain services. A provider must be located no more than fifty miles outside Virginia’s border to be enrolled as an in-state provider.

The total number of Medicaid waiver service providers as well as their availability by region is difficult to assess. The chart below lists the number of providers who received payment for providing HCB Medicaid Waiver services in Fiscal Years 2005 and 2007. The numbers include public, nonprofit, and private providers. Each provider is counted only once for the service it provided, but providers may deliver multiple services under more than one Waiver or have multiple sites at which services are delivered. For example, some licensed Day Support providers also provide those services to clients under the MR Waiver, which also covers that service. Individuals can locate providers in their area through the Provider Search feature available online at www.dmas.virginia.gov/provider_search.asp.

MEDICAID HCB WAIVER SERVICE PROVIDERS

Type of Waiver	Number of Providers		Change	
	2005	2007	#	%
HIV/AIDS ◇	53	59	6	11%
Alzheimer's Assisted Living (AAL) ◇	N/A*	4	N/A*	
Day Support for Persons with Mental Retardation**	N/A*	139	N/A*	
Elderly or Disabled Consumer Directed (EDCD) ◇	587	802	215	37%
Individual and Family Developmental Disabilities (DD) ◇	136	132	-4	-3%
Mental Retardation (MR)**	232	298	66	28%
Technology Assisted (Tech) ◇	58	96	38	7%

Source: ◇DMAS, 2007; **DMHMRSAS, 2007.

*The Alzheimer's Waiver and Day Support Waiver were implemented in Fiscal Year 2006.

Assistive Technology (AT) and Related Services: As noted earlier, AT is provided under a number of programs, each of which has its own policies for access and delivery. The manner in which assistive technology (AT) and related services are provided varies greatly between programs, and an individual with a disability may have access to AT through multiple programs at different times and based on different needs. In addition to their basic procedures, each of these programs has its own appeals processes (such as mediation, informal and formal hearings, etc.) to deal with those situations in which individuals with disabilities, family members, and service providers may disagree on the need for or type of assistive technology. Information on several specialized AT programs follows.

The **Virginia Assistive Technology System (VATS)** is administered by the Department of Rehabilitative Services (DRS) and guided by the Virginia Council on Assistive Technology. There are currently three VATS regional sites: Virginia Tech in the southwest, Old Dominion University in the southeast, and George Mason University in the north. These sites promote public awareness and provide training and technical assistance through networks of local contact points. Additional information, referrals, and other assistance can be obtained through the VATS central office, a toll-free telephone number, and online resources. VATS provided AT services

to 6,716 persons in Fiscal Year 2005, and to 1,846 in FY 2007, a reduction that was caused by a change in federal priorities and funding.

In 2006, VATS obtained grant funds to initiate development of a recycling network statewide, the **Virginia AT Device Reutilization Network (VATNet)**. This network involves public and private partners in local communities (such as Central Virginia Goodwill in Richmond and the Equipment Connection in Fredericksburg) that supply volunteers and generate donations of AT equipment and funds. VATNet's purpose is to provide recycled AT devices at no cost to persons with disabilities and the elderly who do not have other resources. Applications for assistance are available online, by phone, or on location. Each program has its own general information, waiver of liability, and other forms that are completed when the consumer comes to select the needed device. As of October 2007, full-service VATNet programs operate in eleven localities: Martinsville, Lynchburg, Roanoke, Richmond, Petersburg, Virginia Beach, Fairfax, Fredericksburg, Grundy, Culpeper, and the Staunton-Fishersville area. VATS has also established VATNet planning teams in other localities statewide.

DRS's **Woodrow Wilson Rehabilitation Center (WWRC)** provides comprehensive technology assessments and customized technology services through a variety of programs. These may involve special and individualized computer technology, customized rehabilitation engineering and fabrication, augmentative or alternative communication, mobility enhancement, and adaptive devices for daily living and recreation. Access to these services is dependent on the needs of individuals and the policies of each program. Detailed information is readily available from the WWRC Web site, on widely distributed interactive CD-ROMs, and from WWRC directly.

Individuals seeking information or services from the **Virginia Department for the Deaf and Hard of Hearing's (DDHH) Technology Assistance Program (TAP)** may contact DDHH directly or visit one of its Demonstration Centers statewide. Each center displays devices designed to enhance quality of life for persons with hearing loss and provides opportunities for "hands-on" experiences with equipment before purchase. Center staff members demonstrate equipment, explain costs and options, and assist with acquisition. TAP also includes a loan program, TAPLOAN, which allows individuals to try out the equipment for a period of 30 days prior to purchase. There is no waiting list for TAP services, but some individuals may experience waiting periods for AT devices on back order. In Fiscal Year 2005, TAP helped provide equipment to 603 eligible individuals; and, in FY 2007, 523. Fluctuations in the number of program participants between years are often because of changes in reapplication rates each year. Fact sheets on equipment and related services are provided on the DDHH Web site and at Demonstration Centers.

The Virginia **Assistive Technology Loan Fund Authority (ATLFA)**, being renamed as the **NewWell Fund**, does not directly provide AT or related services; it does, however, assist individuals with disabilities, their families, and employers in purchasing. SunTrust Bank acts as ATLFA's (NewWell Fund's) financial partner, and to obtain loan approval, applicants must meet their normal underwriting standards. To make loans more affordable, ATLFA (NewWell Fund)

“buys down” the loan interest rates that SunTrust charges to approved applicants by 4 percent to make loans more affordable. For applicants unable to meet SunTrust’s standard loan requirements on their own, ATLFA (NewWell Fund) may also guarantee loans. For this to happen, applicants must first be rejected by the bank and then provide assurances of creditworthiness and ability to repay the loan to ATLFA’s (NewWell Fund’s) satisfaction. In making its decision, unlike most lending institutions, ATLFA (NewWell Fund) will overlook credit issues related to an applicant’s disability. Application forms are available online at www.newwellfund.org.

As noted earlier, individuals with disabilities could also apply for access to the **Consumer Services Fund** through ATLFA (NewWell Fund) prior to the termination of its funding caused by state budget cuts in the fall of 2007. At the time of this report, budget amendments to restore this funding were pending before the 2008 General Assembly.

Brain Injury and Spinal Cord Injury Services (BI/SCIS): Brain and spinal cord injury services are coordinated by BI/SCIS staff at the Department of Rehabilitative Services (DRS). These staff members serve as an initial point of contact for both other DRS personnel and external customers who need resource or referral information about brain and spinal cord injuries in general, as well as information about specific agency services for persons with neurotrauma. BI/SCIS staff members work closely with the DRS field staff to resolve customer concerns regarding agency services for persons with brain and spinal cord injuries.

The BI/SCIS Department has a collaborative relationship with the Woodrow Wilson Rehabilitation Center’s (WWRC) Brain Injury Services (BIS) Department. A WWRC BI/SCIS staff member serves on the Virginia Brain Injury Council, and another is involved in WWRC’s strategic planning for BIS Program services. During Fiscal Year (FY) 2005, the WWRC BIS Department served 123 individuals; and, in FY 2007, 132. The WWRC Spinal Cord Injury (SCI) program served 148 individuals in FY 2005; and in FY 2007, 166, an increase of 18 (12 percent). During FY 2006, the Brain Injury Discretionary Services (BIDS) Fund supported services to 18 individuals; and during FY 2007, 30.

During the three-year period of FY 2005–2007, 52,658 outreach mailers were sent to individuals reported to the **Virginia Central Registry for Brain Injury and Spinal Cord Injury**. Hospitals are required by the *Code of Virginia* to submit reports on all patients treated for a traumatic brain and spinal cord injury to this DRS Registry. A DRS staff person enters all of the paper hospital reports into the Registry database maintained at DRS Central Office. DRS contracts with the Brain Injury Association of Virginia (BIAV) to conduct outreach, and provides technical assistance to hospitals that are required to report to the Registry. During FY 2007 and FY 2008, DRS has worked closely with the Department of Health to shift all hospital reporting of brain injury to the VDH **Virginia Statewide Trauma Registry (VSTR)**, and legislation is pending in the 2008 General Assembly to codify this change. DRS will still have access to information on injuries reported to the registry so that it can continue outreach activities.

Case Management: Local Community Services Boards (CSBs) are the single point of entry for services within the publicly funded mental retardation system. Under the *Code of Virginia*, § 37.2-500, case management and emergency services are mandated as core services for all individuals eligible for CSB services. Unlike emergency services, however, case management is explicitly subject to the availability of appropriated funds.

The State Board for Mental Health, Mental Retardation and Substance Abuse Services, through *Policy 1035 (SYS) 05-02*, established CSBs as the only approved providers of Medicaid mental health and intellectual disability (mental retardation) case management services. CSBs served approximately 15,801 individuals covered by the Medicaid State Plan during Fiscal Year 2005 and, based on preliminary data, 16,874 during FY 2007. This represents a two-year increase of 1,073 persons (6.8 percent).

Persons under the Mental Retardation (MR) and Day Support Waivers must receive case management services from the CSB or its contracted provider. Under the Developmental Disabilities (DD) and AIDS Waivers, individuals can choose their case management provider from among the public and private agencies that provide this service. The Department of Medical Assistance Services (DMAS) provides case management to individuals served under the Tech Waiver.

Case management for individuals with long-term needs is provided through the Department of Rehabilitative Services' (DRS) **Community Rehabilitation Case Management Services (CRCM)** program. Services are acquired through eight DRS offices statewide at no cost for eligible individuals. The number of individuals receiving CRCM Services increased by 55 (10.5 percent), from 526 in Fiscal Year 2005 to 581 in 2007. Between FY 2005 and 2007, the number of persons on the program's waiting list declined by more than half, from 250 to 105 individuals.

Comprehensive Services Act (CSA): Access to CSA services is complex. Under the CSA, localities are required to have at least two different interagency teams. 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 review, and appointing members to the locality's **Family Assessment and Planning Team (FAPT)**. The composition of these teams is discussed later in this chapter.

The FAPT team assesses the strengths and needs of the youths and families 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's needs cannot be met by the participating agencies, and there are no other community resources available, then the team may use CSA pool funds to purchase services for eligible children.

Each locality develops its own policies and procedures governing access to its CSA system. Some localities allow parents to contact its CPMT and FAPT directly, while others

allow any local agency to bring a case before them and may require that one of its team's participating agencies serve as the point of contact for a family. If a family disagrees with its service plan, it may ask for a review by the CPMT. Emergency services can proceed while this review is taking place. Except where prohibited by state or federal law and regulations, parents may be required to make copayments for services according to a standard sliding fee scale based on ability to pay.

The following table depicts the number and sources of referrals for all children receiving CSA-funded services in Fiscal Years 2005 and 2007. Most children are referred to FAPT by local departments of social services and local school systems, since the mandated populations are foster care children and children with special education needs. During FY 2005 and 2007, these agencies accounted for 81 percent and 84 percent of all referrals, respectively. In each year, social services agencies made a majority of CSA referrals. This trend has remained consistent over the past several years. As the data indicate, between 2005 and 2007 the total number of referrals (based on youths receiving services) increased by 2,211 (13.6 percent).

COMPREHENSIVE SERVICES ACT (CSA) REFERRALS

SOURCE	FY 2005		FY 2007		CHANGE
	# of Persons	% of Total	# of Persons	% of Total	# of Persons
Social Services	9,842	61%	11,735	64%	1,893
Education	3,251	20%	3,790	20%	539
Juvenile Justice	1,294	8%	1,322	7%	28
Interagency Teams	1,027	6%	676	4%	-351
Community Services Boards	664	4%	662	4%	-2
Families	66	<1%	70	<1%	4
Health	2	<1%	6	<1%	4
Other Sources	101	1%	197	1%	96
TOTAL	16,247	100%	18,458	100%	2,211

Source: Virginia Office of Comprehensive Services, January 2008.

Independent Living and Related Services: The 16 regional **Centers for Independent Living (CILs)** and four Satellite CIL offices across the state work directly with individuals with disabilities to identify needs, plan services, and give access to services locally. To the greatest extent possible, each individual has the final word on his or her plan for independent living services, including what services will be provided, how they will be delivered, and the level of independence that the individual wishes to obtain. Individuals with disabilities have a right to a written independent living plan from their CIL, if desired. This plan records mutual agreements regarding services requested, promised, and obtained as well as a timeline for the plan's implementation. CILs in Virginia served approximately 8,000 individuals in Fiscal Year (FY)

2005 and more than 7,200 in FY 2007. CIL services are not available in all geographic areas of the state.

Intake and referral services for the **Department for the Blind and Vision Impaired's (DBVI) Rehabilitation Teaching/Independent Living (RT/IL) Services** are provided by staff members located in six regional offices statewide (Bristol, Fairfax, Norfolk, Richmond, Roanoke, and Staunton). The RT/IL staff works directly with individuals needing assistance to explain services, assist in establishing eligibility, make referrals to appropriate DBVI programs and other community resources, and provide education on available resources. For some DVBI service recipients, independent living and orientation-to-blindness skills training occurs at the **Virginia Rehabilitation Center for the Blind and Vision Impaired**, a residential program located in Richmond. Individuals may also be referred to blindness centers in other states when those programs better meet an individual's needs.

In Fiscal Year 2005, orientation and mobility services through DBVI's Vocational Rehabilitation, Rehabilitative Teaching, and Education Services Programs were provided to 930 individuals; and 859, in FY 2007, a decrease of 71 (7.6 percent). In the DeafBlind program, 204 individuals were provided services in FY 2005, and in FY 2007, 206. A total of 1,200 individuals unable to see with conventional glasses received specialized assistance from DBVI Low Vision Services in FY 2005; in FY 2007, 929.

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. Data on the number of individuals provided independent living services by ESOs were not available.

Outreach, Training, and Technical Assistance: In addition to the numerous other outreach examples covered in this chapter, the **Virginia Department for the Deaf and Hard of Hearing (DDHH)** works with community partners to provide information and assistance to those with hearing loss or speech disabilities as well as the general population. Outreach services are provided by contractors and by the DDHH Central Office staff.

Two key communications' supports provided by DDHH are **Virginia Relay** and the **Interpreter Services Program (ISP)**. Virginia Relay is a free service that enables anyone who is deaf, hard of hearing, deafblind, or has a speech disability to communicate with anyone who is using a standard telephone via text telephone (teletypewriter or TTY) or other assistive telephone devices. Virginia Relay, accessed by dialing 7-1-1, connects an individual with a confidential Communications Assistant, who converts text messages to voice and vice versa to provide the exact conversation. Virginia Relay also provides Voice Carry Over for persons who are deaf or have a hearing loss, but can speak and Hearing Carry Over for persons who have speech impairments but can hear. Virginia Relay operates 24 hours a day, every day of the year.

The DDHH Interpreter Services Program, authorized under *Code of Virginia*, § 51.5-113,

coordinates requests for qualified interpreters to persons who are deaf or hard of hearing from individuals, state courts, state and local government agencies, and other organizations. As required by statute, DDHH maintains and makes available to the public a directory containing contact information for interpreters statewide who meet requirements to be Qualified Interpreters. Individuals can either receive access to directory information online at the DDHH Web site or obtain a hard copy by contacting DDHH by phone or electronic mail. For the most part, interpreters referred by DDHH act as individual contractors, and those employing them are responsible for their fees and expenses. When requested, interpreter services for twelve-step programs and funerals are provided by ISP at no cost.

During Fiscal Year 2007, DDHH had 71,141 Outreach Program contacts, which included training, technical assistance, information and referral, and library services. During 2007, Virginia Relay completed 1,908,328 calls, and ISP coordinated 2,672 requests for interpreter services from state and local agencies and state courts.

Omnibus Budget Reconciliation Act (OBRA): In Virginia, OBRA requirements are fulfilled through a collaboration between the Departments of Medical Assistance Services; Rehabilitative Services (DRS); and Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS). DMHMRSAS, which is responsible for administration of the OBRA program, contracts with DRS and Community Services Boards (CSBs) for distribution of funds for services to qualified individuals, and services are provided or arranged by local DRS Field Offices or the CSBs. For individuals wishing to transition from an institution to a community setting, DRS Rehabilitation Specialists work collaboratively with those individuals, social workers, Centers for Independent Living (CILs), and other resources to ensure appropriate services. The individuals decide where they will live and what community-based services will best meet their needs. These decisions are usually influenced by the availability of housing and community supports available through Medicaid Waivers or other sources. In most cases, support may be continued by a Rehabilitation Specialist if an individual is not receiving case management through a waiver or other program, but OBRA funding for that support does not extend beyond the one-year transition period.

In Fiscal Year 2005, OBRA services were provided to 224 individuals through DRS, and, in 2007, to 188, a decrease of 36 (19.1 percent). In FY 2005, DMHMRSAS provided assessment services under OBRA to 753 individuals; and, in FY 2007, to 767, an increase of 14, or 1.9 percent.

Personal Assistance Services (PAS): For persons receiving vocational rehabilitation (VR) services, personal assistance services are provided as necessary by the **Department of Rehabilitative Services (DRS)** and **Department for the Blind and Vision Impaired (DBVI)**. Persons receiving VR PAS may choose consumer-directed or agency-directed options. Applications for PAS by current recipients of DRS and DBVI vocational rehabilitation services are submitted through their VR counselors along with a copy of a signed Individual Plan for Employment (IPE) as well as a request for a PAS assessment. If there is no IPE, a written plan for extended evaluation or case notes showing the need for PAS must be submitted. For

individuals with brain injury eligible through the DRS VR PAS program, a representative must be designated by the individual to assist the recipient in program management, as needed.

Individuals receiving PAS from the DRS state program have a direct employer-employee relationship with their personal attendants (PAs). As with consumer-directed Personal Assistance Services (PAS) offered through Medicaid Home and Community Based Waivers, a person with a disability (or the person assisting the individual) recruits and hires the 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 is responsible for reviewing PAS applications, conducting initial screening for eligibility, and authorizing related activities by the Centers for Independent Living (CILs). DRS also reviews "start-up packets" for completeness and accuracy, calculates and approves the number of PAS hours the individual with a disability may receive, and determines final eligibility. Following DRS review and approval of timesheets, verification of employment and earnings, and payroll preparation, a contracted bookkeeper handles payroll, taxes, and earnings reports. The CILs are responsible for needs assessments, orientation for persons with disabilities, reassessments, and other support services.

The following table summarizes both the number of persons receiving PAS and those on waiting lists for services. Between Fiscal Years (FY) 2005 and 2007, the number of individuals with disabilities provided by the DRS VR PAS through its vocational rehabilitation program increased from 46 to 62, an increase of 16 (34.8 percent). Eight people were served in FY 2005 and 6 in FY 2007 under the PAS for Individuals with Brain Injury. The number of persons on a waiting list for that program increased dramatically, rising from 7 in FY 2005 to 53 in 2007.

PERSONAL ASSISTANCE SERVICES (PAS) PROVIDED

Program	FY 2005		FY 2007	
	# Served	# on Waiting List	# Served	# on Waiting List
VR PAS	46	N/A	62	N/A
PAS for Brain Injury	8	7	6	53
State PAS (consumer-directed)	166	53	166	54

Source: Department of Rehabilitative Services (DRS), 2007.

Publicly Funded Mental Retardation Services: Community Services Boards (CSBs) are created by municipalities and operate on a local level, but for the most part are independent

authorities and not departments of local city and county governments. As the single point of entry into the publicly funded mental retardation (MR) system, CSBs are required to “provide individualized, effective, flexible, and efficient treatment, habilitation, and prevention services in the most accessible and integrated setting possible.” Each CSB is unique, reflecting its own community and available resources, and delivering its own mix of services directly or through contracts with numerous private providers. As a result, availability of and eligibility for individual service programs may vary widely among CSBs, even for the two “core” CSB services established by the *Code of Virginia*: emergency services, which are mandated, and case management services, which are subject to available funding.

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. 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 or Plan of Care** is developed that guides the implementation of needed services.

In its *Comprehensive State Plan for 2008–2014*, the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) reported the (unduplicated) number of individuals with intellectual disability (ID) served by CSBs from Fiscal Years 1988 through 2006. Over the past three years, the number served increased by 2,968 (12.4 percent). During FY 2004, CSBs served 23,925 persons with ID; 26,050, in 2005; and 26,893, in 2006. While the number served increased by 2,125 (8.9 percent) between FYs 2004 and 2005, the increase slowed to only 843 (3.2 percent) between FY 2005 and 2006.

The DMHMRSAS *Comprehensive Plan* also provides extensive information on waiting lists based on a point-in-time survey of CSBs regarding individuals who had sought any intellectual disability (mental retardation) service and had been assessed by the CSB as needing that service. These estimates reflect only one-third of the year and are considered to be conservative. A comparison of reported data on the estimated length of time spent on CSB MR/ID Waiting Lists for all services, from surveys conducted in 2005 and 2007 is provided below. A majority of those on the CSB Waiting Lists, it should be noted, were receiving some type of service by a CSB but needed other additional or more intensive levels of services or supports.

ESTIMATED LENGTH OF TIME ON WAITING LISTS FOR ALL CSB MR/ID SERVICES

Waiting Time	Jan.-Apr. 2005* # Persons with ID	Jan.-Apr. 2007** # Persons with ID	Change
Less than 1 Month	190	199	9
1 to 3 Months	1,033	683	-350
4 to 12 Months	962	905	-57
13 to 24 Months	735	918	183
25 to 36 Months	583	768	185
37 to 48 Months	392	524	132
49 to 60 Months	400	417	17
61 to 72 Months	168	321	153
More than 72 Months	711	1,229	518
Not Reported	42	28	-14
TOTAL	5,216	5,992	776

Source: DMHMRSAS Comprehensive Plans for *2006–2012 and **2008–2014

As the data indicate, while the number of persons waiting one to three months decreased significantly, the number increased for the longer wait times, most dramatically for those waiting 73 months or more (more than 8 years). The DMHMRSAS Office of Mental Retardation (OMR) attributes the decline in persons waiting one to twelve months to the availability of 700 new MR Waiver slots in July 2006, the single largest influx since 1991. Despite this influx, comparing the two-year data, the total number of persons waiting for any CSB service increased by 776.

According to the *DMHMRSAS Comprehensive Plan for 2008–2014*, the estimated number of weeks that individuals waited prior to actually receiving specific services varies significantly by type of service. Adults seeking MR/ID Case Management in the 2007 survey period, for example, were estimated to wait more than 15 weeks for services; youths, 8.5 weeks. Adult MR/ID Residential Services generally had the longest estimated waiting time for access, ranging from 49.5 weeks for Supported Residential Services to 106.4 weeks for Intensive Residential Services.

Services for Virginians Who Are Elderly: The Virginia Department for the Aging (VDA) provides referral, coordination, technical support, and oversight for the 25 independent **Area Agencies on Aging (AAAs)** and other contractual partners. AAAs are the key resource and initial point of access for older citizens seeking information and assistance. Specific programs and services offered by each agency are determined by its regional needs and resources under the guidance of a local advisory board, and thus vary greatly from one agency or community to another. In Fiscal Year 2005, the AAAs provided services to 59,126 persons; and in FY 2006, to 53,873.

VDA is also engaged in several other initiatives to improve access to services and technical assistance for elderly citizens and their families. A key priority in services to Virginians who are elderly has been the focus on development of an electronic single-point of entry for health and long-term care support. **SeniorNavigator**, supported by VDA, has been nationally recognized for its best practices in the field of health and aging information. This public-private partnership, which receives state and corporate funding, maintains an interactive database of more than 19,000 programs and services to help citizens both find the various community options available and determine which best match their needs.

In partnership with AAAs, multiple state agencies, SeniorNavigator, and others, VDA is developing the **No Wrong Door** initiative for the Commonwealth. Funded through a three-year federal **Aging and Disability Resource Center (ADRC)** grant, this centralized, interactive, online system will provide accurate and timely information to consumers, family members, providers, and state agencies that care for citizens. It will also feature assessment, case management, and eligibility tools that will enable providers to assist consumers in locating and applying for services. A more detailed overview of the ADRC grant project, which will support nine pilot projects across the state, can be found in House Document Number 12 (2006), the "*No Wrong Door*" Study.

The **Public Guardianship and Conservator Program**, also managed by VDA, does not have sufficient funding to support all localities and individuals needing this service. Therefore, each local agency is designated a maximum number of individuals who can be served based on available funds. In areas where services are available, some agencies have reached their maximum, and others have a waiting list for services.

Where Guardianship and Conservator Program services are available, initial identification of individuals needing assistance, regardless of age, is provided by adult care facilities, Department of Social Services' Adult Protective Services, hospitals, and other organizations that serve indigent or incapacitated persons. These agencies present relevant information to a multidisciplinary panel of the Local Guardianship program, which determines if that program can best provide services. Subsequently, the referring agency requests a guardianship or conservatorship hearing by the Circuit Court. If the court finds the person to be incapacitated and in need of a guardian or conservator, the Local Guardianship program may be recommended to the court. After approval by the court, the Local Guardianship program takes responsibility for the incapacitated person and acts on his or her behalf. A guardian assumes responsibility for decision-making for either some or all aspects of the person's life, while a conservator is responsible for management of the individual's property and financial decisions.

In Fiscal Year 2005, 212 persons received services through the Public Guardianship and Conservator Program; in FY 2007, 580. A study conducted by the Virginia Tech Center for Gerontology in 2007 estimated that there are 1,441 indigent and incapacitated persons in Virginia for whom no one is willing or able to act as a guardian.

To enter the Department for the Blind and Vision Impaired's (DBVI) **Older Blind Grant Program**, older Virginians can contact any one of the regional DBVI offices mentioned earlier.

Staff members at those offices can explain available services, assist in establishing eligibility, and make referrals to specific DBVI programs or other community resources as appropriate. In Fiscal Year 2005, funds from this grant program supported services to 2,306 individuals; and in FY 2007, 2,178, a decrease of 128 (5.6 percent).

Program for All-Inclusive Care for the Elderly (PACE) 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. In localities that have PACE, individuals older than age 55 who are screened by the local preadmission team and found eligible for nursing facility services are offered PACE services. If the individual wishes to participate, the prescriber refers him or her to the program. Individuals older than age 55 who live in an area covered by a PACE may also directly request a preadmission screening to see if they qualify for nursing facility placement and thus for PACE.

On November 1, 2007, Sentara Senior Community Care (SSCC) was designated as Virginia's first PACE provider, and enrolled 123 individuals during its first month of operation. SSCC will provide PACE services to the localities of Chesapeake, Virginia Beach, Norfolk, and Portsmouth. In February 2008, the Riverside PACE in the Hampton Roads area will begin operations, and during calendar year 2008, additional PACE programs will be developed and implemented in Northern Virginia, Big Stone Gap, Cedar Bluff, Lynchburg, and Richmond.

D. What Community Living Supports Are Available?

Basic descriptions of the services encompassed by Virginia's system of community supports have already been included in the identification, eligibility, and access sections above. Additional information, where appropriate, appears below. Most programs offer a wide variety of specific services, some of which are unique to a particular program or population while others are shared by multiple programs or populations. The reader is encouraged to consult each program's administering authority for additional information.

Medicaid State Plan Services: Services covered under the Medicaid State Plan of publicly funded health insurance and its components fall into two categories. Federal regulations require all states to provide specific services that are referred to as "mandatory services." "Optional services" are those that a state may choose to provide, but, once that choice has been made, the state must provide those services to all eligible persons. The mandatory and optional services covered by the Medicaid State Plan and related publicly funded insurance programs in Virginia may be found in the Health chapter of this report. Additional information on covered services related to early and periodic screening, diagnosis, and treatment (EPSDT) for children can be found in the Early Intervention chapter.

Home and Community Based (HCB) Medicaid Waivers: Other than the required mandatory and optional services that apply to basic Medicaid State Plan coverage, and are available to all HCB waiver participants, provisions for certain waiver-specific services vary. The availability

of any waiver or waiver service is dependent on, and therefore limited by, annual state appropriations made by the Virginia General Assembly to match federal funds approved by the U.S. Congress. Relevant details by waiver follow.

Based on individual need, the **Mental Retardation (MR) Waiver** provides for crisis stabilization, therapeutic consultations, environmental modifications, skilled nursing services, medication monitoring, and personal emergency response systems (PERS). It also covers residential supports both in-home and in congregate settings; day support; both agency and consumer-directed companion, personal assistance, and respite care services; prevocational services; supported employment; and assistive technology.

Under the **Day Support Waiver**, services currently available are case management, day support services, prevocational services, and supported employment. Supported employment was added as a service under this waiver in Fiscal Year 2008.

Supports covered by the **Individual and Family Developmental Disabilities (DD) Waiver** are similar to those for the MR Waiver, except that the DD Waiver does not provide support in congregate settings and does include family and caregiver training.

The **Elderly or Disabled with Consumer Direction (EDCD) Waiver** funds medication monitoring, agency- or consumer-directed personal care services, adult day health care, personal emergency response systems (PERS), medication monitoring, and up to 720 hours of agency or consumer-directed respite care.

The **Technology Assisted (Tech) Waiver** provides for personal care (adults only) and durable medical equipment. Environmental modifications and assistive technology are also covered, 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 of individuals younger than age 21 who may receive this service 24 hours per day during the first 30 days of having the Tech Waiver.

Case management, nutritional supplements, private duty nursing, agency- or consumer-directed personal care in or outside the home, and up to 720 hours per year of agency- or consumer-directed respite care are available under the **AIDS Waiver**.

Under the **Alzheimer's Assisted Living (AAL) Waiver**, individuals may receive assisted-living services (including assistance with daily living activities, housekeeping, and supervision); medication administration; and therapeutic and recreational programming based on the person's needs and interests. Services, which are paid on a per diem basis, are available 365 days a year in a supervised assisted-living environment. Fourteen (14) days annually are allowed for home visits. Case management is not a covered service under this waiver. Growth of this program has been slow. Marketing efforts targeted to potential providers and recipients is underway by DMAS.

Assistive Technology (AT) and Related Services: The Medicaid State Plan, Home and Community Based Waivers, vocational rehabilitation services, Individualized Education Programs for school children, Omnibus Budget Reconciliation Act, Program for All-Inclusive Care for the Elderly, and other services all have provisions for assistive technology. Specific information on those programs are covered elsewhere in this report. Information on several specialized programs specifically related to assistive technology follows.

As previously mentioned, the Department of Rehabilitative Services' (DRS) **Woodrow Wilson Rehabilitation Center (WWRC)** is a key provider of assistive technology and related services including:

- **Comprehensive Technology Assessments and Customized Technology Services:** An interdisciplinary team evaluates individual AT needs.
- **Assistive Listening and Alerting Devices Assessment:** An audiologist provides evaluation, consultation, and training for individuals who are deaf or hard of hearing related to the selection and use of devices to help them live independently in their home communities. Consultations are also provided to case managers, employers, and others regarding selection and use of these assistive listening devices.
- **Assistive Computer Technology (ACT) Program:** The interdisciplinary ACT Team evaluates each individual's abilities and identifies safe, effective, adaptive computer technologies, which may include computer hardware and software. Services typically are provided in the ACT lab, but services are available once a month through mobile ACT clinics held in Roanoke, Alexandria, and Abingdon-Wytheville.
- **Adaptive Driving Program:** Occupational therapists with specialized training provide evaluations of the individual's driving potential, devices required for safe and effective vehicle control, and on-the-road training in their use. These therapists also advise individuals on van and car modifications for wheelchair access and security.
- **Augmentative and Alternative Communication (AAC) Program:** Speech therapists work with individuals who have severe speech impairments or who have no functional speech. Solutions range from low to high technology applications depending on what is most appropriate for the individual. Training to use the applications in daily living is included.
- **Rehabilitation Engineering Program:** Rehabilitation engineers work directly with individuals with disabilities, the teams described above, and rehabilitation specialists throughout the DRS system. They provide recommendations and guidance on assistive devices as well as modify existing devices or create customized AT that enables individuals with physical disabilities to live more independently. They also may identify strategies that could eliminate the need for assistive devices and assist employers with job accommodations for workers with disabilities.

Through its central office in Richmond, three regional sites, and its Web site, DRS's **Virginia Assistive Technology System (VATS)** provides extensive information on AT devices

and equipment and how they are used, AT vendors, funding options, and resource lists for a variety of service providers. The VATS Web site provides both a toll-free number and a Web site link for each regional site and a toll-free number for the central office.

Through public and private partners, VATS's new **VATNet** recycling network provides AT devices and equipment to people with disabilities and the elderly who do not have public or private insurance and cannot afford to purchase the AT needed. Because the AT is donated, there is no charge to the individual.

Additional AT services are provided by Virginia's Departments for the Deaf and Hard of Hearing (DDHH) and for the Blind and Vision Impaired (DBVI). For example, Assistive Technology Demonstration Centers across Virginia operated by **DDHH's Technology Assistance Program (TAP)** distribute fact sheets and demonstrate listening, alerting, and signaling devices, text and other types of telephones, and other AT options. They also describe costs and identify suppliers. As noted earlier, TAPLOAN sites provide equipment for up to 30 days for individuals who are considering its purchase or whose own equipment is being repaired.

DBVI Rehab Engineers perform individual and work site evaluations and consult with employers to design accessible work environments. DBVI's Rehab Engineering staff monitors advances in technology and develops best practices standards and guidelines. They also work with designers and manufacturers to test adaptive technologies in real world situations. Where off-the-shelf products are inadequate, they create specialized software and databases, modify existing products, and integrate specially adapted products into work and home environments.

As mentioned earlier, the **Assistive Technology Loan Fund Authority (ATLFA)**, now being renamed as the **NewWell Fund**, assists individuals with disabilities, their families, and employers in obtaining loans for assistive technology (AT) and other adaptive and accessibility needs. Products and services that can be funded through ATLFA- (NewWell Fund) subsidized loans include home and vehicle modifications, telework accommodations, assistive devices, information technology, and training in their use. ATLFA (NewWell Fund) can also arrange for and fund consumer counseling for loan applicants who need application assistance. In addition, ATLFA (NewWell Fund) can pay for assessments related to obtaining AT equipment, when alternative funding sources are not available.

ATFLA (NewWell Fund) made 232 loans during Fiscal Years (FY) 2006 and 2007. Seventy-five in 2006 and 56 in 2007 were Direct Loans. In FY 2006, 24 loans were Non-Guaranteed and 28 were Guaranteed. In FY 2007, 27 were Non-Guaranteed and 22 were Guaranteed. In FY 2007, 27 loans were Non-Guaranteed and 22 were Guaranteed. AT services purchased by customers with these funds included 128 van and vehicle modifications, 18 home modifications, 53 hearing aids, 9 wheelchairs and scooters, 8 computers and electronic devices, and 13 other forms of AT. Three telework loans were also financed.

In addition, the **Consumer Services Fund (CSF)**, which is administered by ATLFA (NewWell Fund), served 90 individuals in Fiscal Year (FY) 2006 using \$409,447 in state general funds. In FY 2007, 102 individuals were given access to this DRS fund "of last resort," using

\$420,441 in state general funds. Because of revenue shortages and state budget cuts, the CSF was suspended in the fall of 2007.

Brain Injury and Spinal Cord Injury Service (BI/SCIS): Services for persons with brain injury or spinal cord injury are designed to facilitate community reintegration. An interdisciplinary support team works with the individual and his or her sponsor or family members (at the individual's discretion) to develop and achieve vocational and independent living goals. Assistance in transitioning to other community supports and training for employers and family members are provided as appropriate. For persons with spinal cord injury, services emphasize treatment planning and intervention to teach self-sufficiency, responsibility for managing personal and physical needs, and vocation preparation.

By state law, hospitals in Virginia must report any person treated for a traumatic brain injury or spinal cord injury to the **Central Registry for Brain Injury and Spinal Cord Injury** created under *Code of Virginia*, § 51.5-11, and managed by the Department of Rehabilitative Services (DRS). Working through the Brain Injury Association of Virginia (BIAV) and the Spinal Cord Injury Services Program at Woodrow Wilson Rehabilitation Center, this program provides outreach to all individuals reported to the Registry, making them aware of specialized services and supports available in their communities or from state organizations such as BIAV.

In addition, DRS's **BI/SCIS Department** manages specialized services offered through contractual arrangements with nine direct providers that operate fourteen programs statewide, at a total cost of \$3.4 million. These programs' core services include case management, regional resource coordination, and day/clubhouse programs.

BI/SCIS also provides support and technical assistance to other DRS and community-based brain injury services programs, assists DRS offices in resolving consumer complaints, and provides direct training and sponsorship for vocational rehabilitation field staff members and community partners to attend specialized training conferences and workshops. BI/SCIS conducts a Community Support Services Training Program in Richmond to promote training of personnel to provide support services (such as life skills training, positive behavior supports, and circles of support) for people with brain injury who have challenging, complex service needs in order to maintain community living. Training participants include agency staff members; current and potential brain injury services providers; state and local, public and private counselors, and other professionals; and brain injury survivors and family members.

DRS's **Woodrow Wilson Rehabilitation Center (WWRC)** has a significant role within the agency for providing direct services to persons with brain injury or spinal cord injury. WWRC programs provide occupational and physical therapy as well as psychological, neuropsychological, speech-language, life skills, and cognitive rehabilitation therapies, as needed. WWRC programs also offer home and work accessibility assessments, community reintegration activities, and driving and vocational evaluations. Rehabilitation nursing, dietary, pharmacy, radiology, laboratory, and chaplain services are also available. The WWRC SCI

program provides injured persons the opportunity to interact with other persons with spinal cord injury at various levels of rehabilitation.

The **DRS Brain Injury Discretionary Services (BIDS) Fund** supports short-term services, typically provided on an outpatient basis, and also supports the purchase of needed goods such as wheelchairs, assistive technology, communication devices, and other “discretionary” needs that cannot be funded elsewhere. Services may include neuropsychological assessment and counseling; neurobehavioral assessment and intervention; medical and rehabilitation therapies, including physical and cognitive rehabilitation, assistive technology assessments, and purchase of equipment or related services; day program services; and life skills training. Because of limited resources, the BIDS Fund does not pay for either residential services or inpatient medical rehabilitation services.

During Fiscal Years 2006 and 2007, BIDS Funds were also used to provide state matching funds for Virginia’s Traumatic Brain Injury (TBI) federal grant, funded under the Traumatic Brain Injury Act. The TBI federal grant focuses on systems change and community-level activities designed to increase capacity for service delivery but cannot fund direct services to individuals with brain injury. This grant supported full- and part-time central office staff members located in the Brain Injury Association of Virginia’s (BIAV) Richmond office who supervised and worked closely with four state-funded Regional Resource Coordinators (RRCs) who provided public awareness, outreach, information, and referral services to underserved communities in the Fredericksburg-Warsaw, Northern Neck–Middle Peninsula, Harrisonburg–Shenandoah Valley, and Lynchburg-Farmville areas. While advocating for the needs of people with brain injury and building coalitions in these areas, RRCs reached more than 20,000 people per year through new or expanded support groups, workshops, public awareness events, presentations, information and referral services, and BIAV’s newsletter and Web site.

Case Management: As the provider of publicly funded mental retardation/intellectual disability (MR/ID) case management, local **Community Services Boards (CSBs)** are responsible for outreach leading to the identification of individuals with intellectual disabilities who need case management services, assessment of their needs, and planning services to meet those needs. CSB case managers refer individuals to appropriate service providers, assist them in arranging for services, and help coordinate service delivery. They are also responsible for monitoring the quality and effectiveness of service delivery, advocating for adjustments as their needs change, and facilitating community integration.

With the exception of individuals receiving the Elderly or Disabled with Consumer Direction (EDCD) Waiver who are neither elderly nor on the Mental Retardation (MR) or Developmental Disabilities (DD) Waiver Waiting Lists, recipients of **Home and Community Based Waivers** also receive case management similar to that described above. Waiver services case managers ensure the development, implementation, and modification of Consumer Service Plans. They link individuals with appropriate community resources, coordinate the services provided, and monitor quality of care. Case management services are available as soon as

individuals are found to be waiver eligible, regardless of whether that waiver has been obtained or services under it have begun.

Community Rehabilitation Case Management Services (CRCM) provided by the Department of Rehabilitative Services (DRS) develop, monitor, and modify service plans, provide referrals to and coordinate between service providers, and ensure the quality of service delivery for persons with long-term, multifaceted needs. The program provides specialized services to persons with disabilities who are unable to obtain access to these services in nursing facilities or through the Medicaid State Plan. Services are geared toward maximization of self-determination and independent living

Comprehensive Services Act (CSA): Family Assessment and Planning Teams (FAPT) are responsible for identifying, planning, and coordinating services for at-risk children covered by the CSA. The goal is to serve children and their families in their homes, schools, and communities with appropriate services and supports whenever possible. Because these services are closely tailored to the unique needs of each child, there is no specific menu of services. Within statutory and policy guidelines, a full range of community services are possible, such as comprehensive assessments, crisis stabilization and intervention, behavioral aides, respite care, mentoring, mental health services, substance abuse services, intensive in-home services, specialized wraparound services, therapeutic day treatment, after school services, vocational services, independent living services, special education private day programs, or residential care.

Independent Living and Related Services: As a 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. Helping individuals to develop personal and systems change advocacy skills is also a fundamental part of the independent living mission. Most CILs provide additional services beyond their core responsibilities, such as linkages to housing resources. 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 in schools as well as mentoring and skills training. Many stage recreational events that bring together local residents with and without disabilities.

The **Department for the Blind and Vision Impaired (DBVI)** promotes the functional independence of youths and adults who are blind and vision impaired by developing their independent living skills through its **Rehabilitation Teaching/Independent Living (RT/IL) Services**. This program provides individualized-needs assessments, adjustment counseling, information and referrals, and skills training. Training topics include advocacy and outreach, orientation and mobility, daily living and home management skills, and Braille and other forms of communication. Assistive technology and other specialized services are provided as well. In addition, education to family members and others who wish to assist the individual can be provided. DBVI rehabilitation teachers located across the state generally provide these services in the individual's home.

Orientation and mobility training are especially important for individuals experiencing severe vision loss. The ability to travel safely and efficiently has a direct impact on an individual's success in participating in school, employment, and community living. **Orientation and Mobility Specialists** develop individualized training programs designed to teach the use of the long cane as a travel tool as well as specific techniques to allow consumers to establish and maintain their orientation to their surroundings.

DBVI's **DeafBlind Services** program ensures that individuals with both vision and hearing impairments are full participants in all of its major programs and provides additional specialized services that target their unique needs, particularly in the area of communication. Staff of DeafBlind Services also provide consultation and technical assistance to other DBVI programs, external public and private organizations, and the general public.

Vision examinations and optical aids for persons of all ages who cannot see with conventional glasses are supplied by a statewide network of providers managed by DBVI's **Low Vision Services**. 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.

Omnibus Budget Reconciliation Act (OBRA): Services for individuals covered by OBRA who reside in nursing facilities or are transitioning to community settings generally fall under the Medicaid State Plan option Day, Health, and Rehabilitation. They include case management and personal assistance services for eating, hygiene, self-care, medication management, and travel. Crisis intervention, psychotherapy, individual and group counseling, and behavior management training are also included, as are training in communication skills, independent living, and utilization of community resources. Educational assistance, prevocational training, and supported employment are covered as well. Assistive technology, rehabilitation engineering, and transportation to and from service providers are included as appropriate.

OBRA staff members may also assist individuals in transitioning from institutional to community living settings. Transition services include, but are not limited to, services 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.

Outreach, Training, and Technical Assistance: Descriptions of numerous outreach and training programs available from agencies across the Commonwealth appear throughout this chapter, in this and earlier sections, and do not need to be repeated here. Programs specifically referenced in this chapter include the **Department for the Deaf and Hard of Hearing's (DDHH) Outreach Services, Virginia Relay, Virginia Interpreter Services Program, and Directory of Qualified Interpreters.**

Personal Assistance Services: Whether obtained through Home and Community Based Medicaid Waivers, Vocational Rehabilitation PAS, or one of the DRS state-funded PAS programs, these services provide assistance with a broad range of physical and personal needs such as transferring, bathing, dressing, eating, and general mobility. Personal Assistants may

also be involved with assistive technology evaluation, transition services, and rehabilitative engineering.

Publicly Funded Mental Retardation Services: Eight categories of core mental retardation services are provided by local **Community Services Boards (CSBs)** either directly or through contracts with other public or private service providers. As noted earlier, CSBs are only mandated to provide emergency services and, subject to available appropriations, case management services. The other core services that CSBs may offer include outpatient, residential, prevention, early intervention, employment, and day support services. Other limited services offered by some CSBs include consumer monitoring and assessments or evaluations. 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.

Services for Virginians Who Are Elderly: Principal services are provided by 25 local **Area Agencies on Aging (AAAs)**, either directly or in collaboration with health and social services departments, nonprofit organizations, and other local resources. Services offered vary widely between AAAs, but typically include adult day care; programs that check on individuals in their own homes to make sure 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 along with education, recreation, social, and volunteer opportunities. Some AAAs also provide employment, home heating and cooling, and tax-filing assistance, transportation to and from activity centers or other programs, and help completing applications for services.

In addition to their own information and referral services, Area Agencies on Aging make extensive use of SeniorNavigator's statewide online and toll-free telephone system. To expand access to this system, some localities offer local **SeniorNavigator Centers**. Staffed by volunteers, these centers provide free assistance to individuals who either lack computers or otherwise need help with online access. Local availability and schedules for these centers vary.

The types of guardianship and conservatorship available through the Virginia **Public Guardianship and Conservator Program** vary. The Circuit Court judge determining the need for this service has flexibility to help preserve as much independence for the individual as possible. Guardianships may be on an emergency or temporary basis, applicable for a limited time or to decisions that correct conditions causing an emergency. A limited guardianship is made when decisions are needed only for specific issues, such as health care, and similarly, a limited conservatorship may be created for certain specific money matters. A standby guardian assumes that role after the death of the person currently responsible for the care of another. Other legal alternatives to guardianship or conservatorship can also be exercised in Virginia, including power of attorney, advanced medical directives, representative payee, and various

types of trusts. The details of these alternatives are beyond the scope of this report, and appropriate legal and administrative authorities should be consulted for more information.

The **Older Blind Grant Program**, administered by the Virginia Department for the Blind and Vision Impaired (DBVI) and funded by the U.S. Department of Education, supports services for older Virginians provided by other DBVI programs, and has been covered elsewhere in this chapter.

The **Program for All-Inclusive Care for the Elderly (PACE)**, administered by the Department of Medical Assistance Services (DMAS), provides the full scope of services available under the Medicaid State Plan, and a full list of its services is specified both in state statute (12VAC30-120-64) and in that plan. They include primary health care; case management and other social work services; adult day care; restorative therapies, including physical, occupational, and speech-language pathology therapies; personal care and supportive services; home health and durable medical equipment; respite care; transportation; prescription drugs—medications; recreational therapy; and other specialty services. Each participant receives a multidisciplinary assessment and treatment planning.

Service System Planning: The local **Disability Services Boards (DSBs)** and **Statewide Independent Living Council (SILC)** do not provide direct services to the public but do have specific responsibilities related to supporting and improving Virginia's disability services system. By statute, DSBs are required to assess and report local needs and priorities for services to people with physical and sensory disabilities. This assessment must be updated every three years and must include an opportunity for public comment. DSBs are also expected to serve as an information and referral source for local governments regarding the requirements of the Americans with Disabilities Act (ADA) and, in general, to facilitate the exchange of information on resources and best practices between localities and within their communities. As the local administrators of **Rehabilitative Services Incentive Funds**, authorized under *Code of Virginia*, § 51.5-50–51, DSBs are expected to use these moneys to leverage other public and private resources that will expand and improve local services.

The SILC's primary responsibility is to prepare the **State Plan for Independent Living** in collaboration with state agencies and the public. The purpose of the State Plan is to ensure the existence of planning, financial support, and coordination to address Virginia's needs in the areas of independent living, vocational services, and other programs that support people with disabilities. In 2007, the SILC made a significant commitment to improving access to affordable, accessible housing for persons with disabilities.

E. Cost and Payment for Community Living Supports

Extensive information is available about funding for state agency programs and services relevant to community supports for people with disabilities. The information contained in the three charts below is drawn from a variety of these sources and can be helpful in determining the

level of funding available for the initiatives described in this chapter. Wherever appropriate and possible, the numbers of individuals served and on waiting lists for services have been included along with expenditure amounts. Notes accompanying each chart attempt to clarify details regarding their entries. A comprehensive discussion of specific allocation and payment mechanisms for every program is not feasible in this report, however, because of the number and complexity of agencies and initiatives that contribute to Virginia's community supports system. Appropriate administrative agencies should be contacted for additional information.

State Medicaid Expenditures: The financial significance of Medicaid to the state system of community living supports cannot be overstated. Virginia's Department of Medical Assistance Services (DMAS), identifies Medicaid as being the largest health-care program in the Commonwealth. DMAS reported that the most significant growth in Medicaid enrollees over the past decade (1996–2006) has been among two groups: The number of enrollees categorized as blind and disabled increased by 46 percent; and the number of children covered by 25 percent. Medicaid expenditures for Fiscal Year 2007, by recipient category, are provided in the following table. As the data indicate, Virginians who are blind or disabled comprised only 18 percent of Medicaid recipients, but accounted for almost half of all Medicaid expenditures because of higher use of acute and long-term services.

FY 2007 MEDICAID RECIPIENTS AND EXPENDITURES

Medicaid Category	Number of Recipients	Percent of All Recipients	Percent of All Expenditures
Elderly	81,807	10%	21%
Blind and Disabled	147,253	18%	47%
Children	466,302	57%	23%
Adults	122,711	15%	9%

Source: Department of Medical Assistance Services (DMAS), January 11, 2008.

The next chart provides data on Virginia's **Home and Community Based (HCB) Medicaid Waivers**. Because of the inclusion of additional information required to ensure accuracy, waiver information is reported separately from other community support programs and services, which are covered in a separate chart following the Waiver chart. Unless otherwise indicated, the information provided covers the most recent reporting period available, typically state Fiscal Year 2007, from July 1, 2006, through June 30, 2007. Throughout the chart, "N/A" indicates "not applicable."

In its October 2005 report, *Assessment of Reimbursement Rates for Medicaid Home and Community Based Services*, Virginia's Joint Legislative Audit and Review Commission stated that services provided under HCB Medicaid Waivers were typically more cost effective than institutional care and their increased use could yield additional state savings for those recipients who would otherwise be at risk of having to enter an institution.

FISCAL YEAR 2007 VIRGINIA HOME AND COMMUNITY BASED (HCB) WAIVERS

Program or Service	# Served	# on Waiting List	Waiver-Specific Costs^A	Waiver Acute Care Costs^B	Total Cost	State Funds^C	Federal Funds^C	Average Per Capita Cost^D
AIDS Waiver	94	No List	\$812,272	\$1,682,675	\$2,494,948	\$1,247,474	\$1,247,474	\$19,396
Alzheimer's Waiver	18	No List	\$148,600	\$6,819	\$155,419	\$77,710	\$77,709	\$8,743
Day Support Waiver	265	3,872	\$2,957,816	\$2,763,013	\$5,720,829	\$2,860,415	2,860,414	\$21,588
Developmental Disabilities (DD) Waiver	408	Total 590	\$9,507,150	\$4,529,206	\$14,036,355	\$7,018,178	\$7,018,177	\$34,403
		Level 1 246						
		Level 2 348						
EDCD Waiver	13,965	No List	\$190,622,941	\$74,717,724	\$265,340,665	\$132,670,333	\$132,670,332	\$19,396
Mental Retardation (MR) Waiver	6,850	Urgent 2,017	\$381,861,078	\$80,222,932	\$462,084,010	\$231,042,005	\$231,042,005	\$67,516
		Non-Urgent 1,855						
		Planning 569						
Tech Waiver	384	No List	\$26,738,452	\$17,060,718	\$43,799,170	\$21,899,585	\$21,899,585	\$114,646
Medicaid State Plan ^E	75,143	Not Applicable			\$239,163,691	\$0	\$239,163,691	\$3,183

- A. Costs include only those for services specifically provided under each HCB Waiver.
- B. Costs include Acute Care medical services (doctor visits, X rays, medications, etc.) and transportation that were received by individuals enrolled under each HCB Waiver but were not approved services under those waivers.
- C. Waiver costs are split evenly between Federal (50 percent) and State (50 percent) funds. Federal funds cover all (100 percent) of Acute Care (nursing facility, inpatient hospital, ICF-MR) costs under the Medicaid State Plan. The sum of Waiver-Specific plus Waiver Acute Care Costs and the sum of Federal plus State Costs for each Waiver may not exactly equal Total Cost because of rounding.
- D. Average Per Capita Cost for each Waiver, as calculated by DMAS, was determined by adding the per capital cost for Waiver-Specific services to the per capita cost for Waiver Acute Care services for each Waiver. Since different numbers of individuals with a Waiver receive Waiver-Specific services and Waiver Acute Care services, this is not the same as the sum of Waiver-Specific Costs plus Waiver Acute Care Costs divided by the number of persons Served by that Waiver. The latter calculation may higher for some Waivers and lower for others.
- E. Combination of all Medicaid State Plan Acute Care institutional services (nursing facility, inpatient hospital, ICF-MR) associated with the five Waivers, both in Number Served and Total Cost. The Per Capita Cost is the combined cost of these institutional acute care services across waivers divided by the total number of institutional acute care recipients across waivers.

FISCAL YEAR 2007 VIRGINIA COMMUNITY SUPPORTS

Program or Service	# Served	# on Waiting List	State Funds	Federal Funds	Other Funds	Total Funds	Per Capita Cost ^A
ASSISTIVE TECHNOLOGY (AT)							
AT Loan Fund Authority (ATLFA), a.k.a. NewWell Fund ^B	209	0	\$420,441	\$1,416,928	\$0	\$1,837,369	N/A
DDHH Technical Assistance Program (TAP) ^C	523	No List	\$381,540	\$0	\$0	\$381,540	N/A
Virginia AT System (VATS)	9,108	0	\$124,000	\$365,000	\$189,000	\$678,000	\$74
WWRC AT Services ^D	306	No list	N/A	N/A	N/A	N/A	N/A
BRAIN INJURY (BI) AND SPINAL CORD INJURY (SCI) SERVICES							
BI Discretionary Services (BIDS) Fund ^E	30	6	\$100,000	\$0	\$0	\$100,000	\$3,333
WWRC BI Services ^F	132	14	\$130,878	\$251,488	\$0	\$382,366	N/A
WWRC SCI Services ^G	166	No list	N/A	N/A	N/A	N/A	N/A
Virginia BI and SCI Registry ^H	18,719	N/A	\$82,232	\$0	\$0	\$82,232	\$4
DRS BI and SCI Services ^I	>2,000	N/A	\$3,400,000	\$0	\$0	\$3,400,000	\$1,700
CASE MANAGEMENT (CM)							
DRS Community Rehab. CM (CRCM) ^J	581	105	507,643	0	0	507,643	N/A
Medicaid State Plan Option Mental Retardation CM (non-waiver)	Not Available						
Home and Community Based Waiver CM ^K	Not Available						
COMPREHENSIVE SERVICES ACT (CSA)^{L,M,N}							
CSA Mandated Services	17,334		\$213,697,075	N/A	\$119,409,739	\$333,106,815	\$19,217
CSA Non-Mandated Services	1,124		\$5,859,192	N/A	\$3,274,002	\$9,133,193	\$8,126
Total CSA	18,458		\$219,556,267	N/A	\$122,683,741	\$342,240,008	\$18,542
INDEPENDENT LIVING (IL) AND RELATED SERVICES							
Centers for Ind. Living (CILs) ^O	7,200	N/A	>\$5,300,000	>\$1,500,000			N/A

FISCAL YEAR 2007 VIRGINIA COMMUNITY SUPPORTS

Program or Service	# Served	# on Waiting List	State Funds	Federal Funds	Other Funds	Total Funds	Per Capita Cost^A
DBVI Rehab. Teaching/IL and Orientation and Mobility Services ^P	RT/IL 2,784	No List	\$1,442,669	\$1,006,193	\$89,261	\$2,538,123	N/A
	OandM 859						
DBVI DeafBlind Services ^P	206	No List	\$115,754	\$24,595	\$1,094	\$141,443	N/A
DBVI Low Vision Services ^P	929	No List	\$112,733	\$41,244	\$195,673	\$349,650	N/A
PERSONAL ASSISTANCE SERVICES (PAS) (Non Waiver)							
DRS Brain Injury PAS	6	53	\$77,000	0	0	\$77,000	\$12,833
DRS State-funded PAS	166	54					
DRS Vocational Rehab. PAS ^Q	62	N/A					
Omnibus Budget Reconciliation Act (OBRA)	188	No List	Not Available				
OUTREACH, TRAINING, AND TECHNICAL ASSISTANCE							
DDHH Outreach	N/A	N/A	\$ 375,250	\$0	\$0	\$375,250	N/A
Virginia Relay ^R	1,908,328 (contacts)	N/A	\$0	\$0	\$14,364,229	\$14,364,229	N/A
PUBLICLY FUNDED MR/ID SERVICES (NON-WAIVER)							
Community Services Boards (CSBs) ^S	17,867	5,964	\$15,793,165	N/A	\$81,197,782	\$96,990,947	\$5,428
SERVICES FOR PERSONS WHO ARE ELDERLY							
Area Agencies on Aging and VDA Contract Services ^T	58,241	Varies by service	\$11,530,852	\$24,716,057	\$14,797,631	\$51,044,540	\$876
VDA Public Guardian and Conservator Program	580	114	\$1,433,460	\$0	\$0	\$1,433,460	\$2,471
VDA Long-Term Care Ombudsman	1,614	N/A	\$291,712	\$412,864	\$451,670	\$1,156,246	N/A
DBVI Older Blind Grant Program ^P	2,178	No List	\$788,535	\$0	\$0	\$788,535	N/A
Program for All-Inclusive Care for the Elderly (PACE)	123	No List	\$1,786,526	\$1,786,526	\$0	\$3,573,052	\$29,049

FISCAL YEAR 2007 VIRGINIA COMMUNITY SUPPORTS

Program or Service	# Served	# on Waiting List	State Funds	Federal Funds	Other Funds	Total Funds	Per Capita Cost^A
SERVICE SYSTEM PLANNING							
Disability Services Boards (DSBs) ^U	N/A	N/A	\$520,000	\$0	\$0	\$520,000	N/A
DSBs Rehab. Services Incentive Fund	740	No List	N/A	\$212,500	\$0	\$212,500	\$287
State Independent Living Council (SILC)	N/Ae	N/A	\$77,575	\$540,530	\$6,250	\$624,355	N/A

- A. Per capita costs are not available or not applicable for all programs and are included only where the agency providing the data deemed that information to be appropriate and available.
- B. The Alternative Financing Program (AFP) operates differently than other funded programs and services within the ATLFA (NewWell Fund) program. It uses a variety of strategies to support credit financing for the purchase of assistive technology. AFP funding comes from a combination of sources, including federal grants, state appropriations, and matching public and private contributions. The principal use of AFP funds is to provide loan guarantees that back individual loans to individuals by SunTrust Bank, the AFP lending partner. SunTrust shares the guarantee with the Loan Fund Authority, and those funds are set aside for repayment of defaults as necessary. For amounts less than \$4,000, AFP makes loans directly to the person with a disability serving as the bank and full guarantor. AFP funds are also used to buy down interest rates on all loans to reduce further the individual's credit obligation.
- C. Technical Assistance Program (TAP) expenditures reflect only equipment costs. Other TAP service costs include loaner equipment, equipment demonstrations, and information-referral services.
- D. No funding is directly allocated for WWRC AT services. They are provided on a fee-for-service basis and are reimbursed by Medicaid, Medicare, DRS, and other sources. As a result, a per capita cost is not applicable.
- E. The number of persons listed includes only those who received direct services from the BIDS Fund under the federal Traumatic Brain Injury (TBI) Act, source of the federal funding shown.
- F. Service recipients typically receive both Brain Injury Services and multiple other services from WWRC; therefore, a calculation based solely on BIS expenditures does not accurately reflect per capita cost for service.
- G. Funding for Spinal Cord Injury Services is not accounted separately from that for other WWRC programs. Approximately 70 percent of this funding is from Title I Vocational Rehabilitation funds; 20 percent, from state general funds; and 20 percent, from fees for service, special funds, or grants.
- H. Total Funds for the BI and SCI Registry include \$25,000 from the BIDS Fund and \$52,232 in DRS General Funds.
- I. The number who received DRS BI and SCI services includes all state-funded BIS Program contracts managed by BI/SCIS. Federal Traumatic Brain Injury (TBI) Act funds support these services but are counted elsewhere.
- J. Number served by DRS Community Rehabilitation Case Management includes active caseloads as well as those receiving only technical assistance, making a calculation of per capita cost inappropriate.
- K. Information on case management provided through Home and Community Based Waivers cannot be disaggregated from other data. Case management is a Medicaid a State Plan service, not a waiver service.
- L. Information is not available on the number of children needing CSA services or who may be on waiting lists for them. Almost 93 percent of children served by CSA are mandated for services. It is unknown how many nonmandated children need services.
- M. Federal Social Services Block Grant funding for CSA services is provided through the Virginia Department of Social Services, and for financial reporting purposes, these funds are considered state funds and are reported under that category.

- N. Local governments are the source of Other Funds for CSA Services.
- O. Per capita cost for the CILs is not applicable because allocated funding covers both direct services to individuals with disabilities and public awareness, training, and technical assistance activities directed at organizations, service providers, families, or other broad constituencies.
- P. DBVI staff members provide multiple services to persons with disabilities through several DBVI programs, and funding covers both personnel costs and purchase of tangible goods and services supplied to those individuals. Therefore, calculations of per capita cost for individual service is not possible.
- Q. Federal funding for DRS vocational rehabilitation Personal Assistance Services reflects actual expenditures, not budgeted amounts.
- R. Number served for Virginia Relay reflects the number of completed calls.
- S. Information is maintained by individual Community Services Boards and is aggregated to the state level by DMHMRSAS. Waiting list count is as of April 2007.
- T. Services provided by Area Agencies on Aging and through VDA contracts, and to which this information applies, are available to both individuals with and without disabilities.
- U. Disability Services Boards (DSBs) do not provide direct services to individuals. Number served includes persons receiving services through DSB-administered Rehabilitation Services Incentive Fund grants jointly administered by the DSBs and DRS, as well members of the general public and local government officials who have received technical assistance and information from the DSBs.

F. Monitoring and Evaluation of Community Living Supports

Home and Community Based (HCB)Waivers: As the administrator of the state's Medicaid program, the **Department of Medical Assistance Services (DMAS)** contracts or otherwise arranges with other entities for most screening, case management, service, and billing-related activities. DMAS remains responsible, however, for ensuring that all Medicaid programs operate in compliance with state and federal laws and regulations and for ensuring the health, safety, and welfare of individuals receiving Medicaid-funded services. DMAS must ensure that the full scope of Medicaid services is available, that covered individuals have a choice of providers, and that an adequate supply of qualified providers has been enrolled in the program to meet demand. DMAS must also ensure that adequate services are provided to covered individuals, that they are of good quality, and that services are added or changed as needed to protect recipients' health, safety, and welfare.

Federal regulations stipulate that DMAS provide for continuing review and evaluation of services paid by Medicaid, including utilization of services by both providers and recipients. To comply, DMAS conducts periodic quality management reviews on all programs. Additional compliance reviews occur when it is indicated that providers are delivering services in excess of established norms and after receipt of complaints or other referrals from agencies or individuals. Providers participating in Medicaid must ensure that requirements for services rendered are met in order to receive payment. Under their required Participation Agreements with DMAS, providers must also 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.

With specific respect to Home and Community Based (HCB) Waivers, DMAS is required to ensure the health, safety, and welfare of individuals served as well as to ensure provider compliance with federal and state regulations. This is accomplished through **Quality Management Reviews (QMRs)** conducted by DMAS. Because of the differences among waivers, the review process is specific to each particular waiver.

Specific monitoring is provided with respect to case management for persons receiving HCB Waivers. Areas monitored for compliance include whether the individual is eligible for the specific services being provided under his or her particular waiver, whether there is an appropriate Individualized Service Plan that is based on a comprehensive and ongoing assessment of the individual's needs, and whether services are being delivered, reviewed, and modified as required by that plan. DMAS also reviews provider qualifications, checks whether services are consistent with billing limitations, and conducts annual level of care reviews. Following completion of a review, the DMAS staff shares its findings with providers in an "exit conference" that includes technical assistance and education. A written report of those findings is also sent to the provider. A provider who fails to ensure the health, safety, and welfare of Medicaid recipients or fails to deliver services in accordance with federal and state regulations may face a variety of sanctions, including reimbursement to Medicaid of funding received up to termination of their Medicaid provider agreement.

The **Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS)** provides additional oversight and monitoring for the Day Support and Mental Retardation (MR) Waivers, over which it has administrative responsibility. DMHMRSAS staff members periodically review Individualized Services Plans for persons under these two Waivers whether the services are through a CSB, another public provider, or a private provider. Staff members 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 DMHMRSAS Office of Licensing or by the DMAS QMR staff.

Assistive Technology (AT) and Related Services: Information on activities and events sponsored by the **Virginia Assistive Technology System (VATS)** is collected and compiled on a routine weekly, monthly, quarterly, and annual basis. During federal fiscal year 2007, the U.S. Rehabilitation Services Administration developed a data-reporting system that will be used annually to report to Congress the impact of AT devices and services. Both VATS Regional Sites and the recycling programs provide a quarterly report to VATS showing how many individuals received various devices, their costs had the persons purchased them, and the resulting cost savings. The quarterly reports also include summative evaluations from large training and conference activities. This information is further compiled at a statewide level and submitted to the Rehabilitative Services Administration for additional review and comment, and it is included in the annual federal report. Follow-up and satisfaction surveys are used to evaluate the value and impact of services.

The **VATS Advisory Council** provides additional oversight and guidance, as does the U.S. Department of Education's Rehabilitation Services Administration (RSA). A three-year plan, approved by RSA in 2005, guides the activities of the Advisory Council. Subsequent annual reports, based on the data collection and review process described above, are compared to that plan to ensure accountability and enable modifications in the plan and VATS activities as indicated.

Quality monitoring and oversight for Assistive Technology (AT) services at **Woodrow Wilson Rehabilitation Center (WWRC)** are provided through its **Durable Medical Equipment (DME) Program**, which is accredited by the Accreditation Commission for Health Care. Information on specific individual satisfaction measures is routinely gathered, and both the process and the measures are reviewed annually by members of the AT Seniors Workgroup. Follow-up phone calls are made to individuals who receive wheelchairs through the WWRC AT program, and information is forwarded to the assigned therapists. Those therapists then contact the individuals for troubleshooting or other follow-up. All information is tracked in a database and reviewed semiannually to determine ways in which to improve service delivery.

Monitoring of the Department for the Deaf and Hard of Hearing's **(DDHH) Technology Assistance Program (TAP)** is the responsibility of the agency's Director, and several related performance measures are included in the DDHH Executive Agreement. Customer comments are routinely documented and concerns are forwarded to the Program Coordinator, the appropriate Outreach Specialist, and the Director as needed. A recent administrative review of TAP identified areas needing improvements, and those improvements are being implemented. Program policies have been updated, reporting mechanisms are being enhanced, and an improved system for evaluating the satisfaction of persons with disabilities is in development.

Telecommunications contracts for **Virginia Relay** are also managed and monitored by DDHH. *Code of Virginia*, § 56-484.7, tasks DDHH with oversight for operations of basic relay services such as TTY-based and Voice Carry Over (CapTel) systems. DDHH oversight includes a variety of activities, such as routine test calls by agency staff members and by contractors, quarterly on-site visits and observations, review of feedback from consumers and from Virginia Relay Advisory Council members, and review of detailed monthly performance and statistical reports. Comments from individuals with disabilities regarding relay services are compiled daily by the Virginia Relay service provider and are reported to DDHH on a monthly basis. DDHH also contracts for external, independent Quality Assurance testing. State and federal contracts with the Virginia Relay provider include specific steps for corrective action for both vendor compliance and individual complaints. DDHH is required to provide annual reports to the Federal Communications Commission on contractor performance and consumer feedback, which includes a log of all consumer complaints.

Oversight for the **Assistive Technology Loan Fund Authority (ATLFA)**, now being renamed as the **NewWell Fund**, is provided by a Board of Directors, which includes the Secretary of Health and Human Services, or designee; an employee of WWRC; a representative from a consumer lender; a certified public accountant; two persons with investment finance

experience; and six persons with disabilities. Based on specific Board duties and responsibilities delineated in the *Code of Virginia*, § 51.5-56, the Board has established bylaws and program policies and procedures to ensure consistent program delivery at all levels of the authority. In 2007, ATFLA (NewWell Fund) completed a Governance Manual and updated its bylaws with Board approval.

ATFLA (NewWell Fund) must also comply with requirements of the federal Rehabilitation Services Administration (RSA), which include providing the results of an annual external audit of its programs that analyzes day-to-day organization, administration, and finances. In addition, ATFLA (NewWell Fund) submits an annual report describing its activities to RSA through the National Technical Assistance component of the Rehabilitation Engineering and Assistive Technology Society of North America (RESNA). This report, which includes general loan applicant demographics related to type of disability and type and amount of loan, is compiled nationally and reported to Congress annually. In its 2006 RESNA report, the ATFLA (NewWell Fund) identified critical issues primarily related to increasing public awareness of its programs and established enhancement of marketing and outreach to people with disabilities as a central priority in coming years. In addition, it developed and initiated systems to ensure collection of timely and reliable data.

Brain Injury and Spinal Cord Injury Services (BI/SCIS): The manager of the **BI/SCIS Program** is responsible for monitoring related services provided within the **Department of Rehabilitative Services (DRS)** and for reporting activities of significance or concern to the Division Director and Commissioner on a weekly basis. In addition, an annual report is submitted to the Division Director and the Commissioner on activities conducted by the BI/SCIS unit, including the number of case consultations with the DRS field staff, the number of DRS staff members and community partners receiving specialized training in brain injury–spinal cord injury, and new activities initiated during the year. During 2007, the BI/SCIS Program Manager instituted the first annual General Meeting of directors, program managers, and fiscal specialists of the state-funded BIS contract programs. The major goals of the two-day General Meeting are to provide technical assistance on administrative and oversight issues, promote sharing of best practices and collaborative efforts to improve service delivery, and provide a venue for program staff to present issues or concerns.

The BI/SCIS Program Manager also has oversight responsibility for the Commonwealth Neurotrauma Initiative (CNI) Trust Fund, the Brain Injury Discretionary Services (BIDS) Fund, the Virginia Central Registry for Brain and Spinal Cord Injury, and the Virginia Brain Injury Council and for monitoring expenditures, activities, and outcomes of nine community organizations operating fourteen state-funded brain injury programs across the Commonwealth. Reports on these activities 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. A written report on the number of people served, types of services provided, and success in attracting nonstate resources is required to be submitted annually to the General Assembly. Again, any issues or concerns of significance are reported to the Division Director and the Commissioner on a weekly basis.

The BI/SCIS staff supports the Virginia Brain Injury Council and provides the Council with updates on agency programs and activities at each quarterly meeting. The Virginia Alliance of Brain Injury Service Providers and the Brain Injury Association of Virginia (BIAV) also work closely with BI/SCIS to maintain accountability for the use of state funds allocated by the General Assembly for brain injury services. Suggestions and concerns raised both internally at DRS and by community partners are considered and discussed, and if feasible, appropriate action is taken. Changes in policies or procedures are made internally following consultation with the DRS Commissioner and the Division Director.

Internal BI/SCIS program expenditures are monitored and reported on a monthly basis by DRS Fiscal Services. DRS Audit completed an internal audit of BI/SCIS unit in 2006, with only a few recommendations. External organizations providing contracted brain injury services are required to submit financial and narrative progress reports to DRS on a monthly, quarterly, and annual basis. These reports must include an annual external audit and other evaluations, such as consumer satisfaction surveys, available to the contractor from internal or external sources.

In 2007, the Joint Legislative Audit and Review Commission (JLARC) completed and published an extensive study, *Access to State-Funded Brain Injury Services in Virginia*, that identified the availability of current services statewide as well as significant service gaps and needs. JLARC made a number of recommendations to improve oversight of contracted brain injury programs, such as closer program monitoring and evaluation as well as requiring annual external financial audits.

BI/SCIS, in collaboration with its state-funded programs, implemented the Web-based Brain Injury Services (BIS) Programs SCORECARD monitoring and evaluation system in the spring of 2007. Using the SCORECARD system, the BI/SCIS Manager monitors and tracks contract expiration dates, progress in expending funds, and other relevant information on a monthly, quarterly, and annual basis. Program expenditures and outcomes data submitted through this tool allow DRS to monitor contract compliance as well as program efficiency and effectiveness in a more structured manner and on a more regular basis. Previously, BI/SCIS hired external consultants to conduct evaluations on programs every two or three years. Although external evaluations will continue, the SCORECARD permits the agency to conduct program tracking and monitoring on an ongoing basis.

With respect to the **Brain Injury Discretionary Services (BIDS) Fund**, requests for goods or services costing more than \$1,000 are reviewed by both the BIDS Fund Program Manager and by the Manager of the Community Rehabilitation Case Management (CRCM) Services program. This review process is designed to provide a check and balance mechanism for decisions regarding the use of BIDS funds. The BI/SCIS Program Manager has overall responsibility for oversight of this funding program.

Although there is no formal internal evaluation of the BIDS Fund, the BI/SCIS Program Manager reports annually to the DRS Commissioner and Virginia Brain Injury Council on its operations, including the number of individuals served and the types and costs of services

provided. DRS reports that, to date, no concerns have been expressed about the management or effectiveness of the BIDS Fund. This includes the findings of outside consultants from Eastern Virginia Medical School who completed a comprehensive evaluation of the program in its second year of operation. Whenever deficiencies or concerns are identified, these are reviewed and remedied through a similar procedure as indicated for other BI/SCIS and Community Based Services activities.

Responsibility for the maintenance and oversight of the Virginia **Central Registry for Brain Injury and Spinal Cord Injury** rests with the BI/SCIS unit and its Program Manager. The Brain Injury Association of Virginia (BIAV) provides technical assistance to all Virginia hospitals regarding compliance with *Code*-reporting requirements. BIAV supplies DRS with monthly reports on these outreach activities, and it reports annually to the Virginia Brain Injury Council, the advisory body to the DRS Commissioner and the agency staff, regarding brain injury-related needs and service recommendations. Follow-up on significant issues identified in these reports are jointly discussed and acted on by BIAV and DRS as indicated.

Efforts to improve the outreach to persons with brain injury or spinal cord injury have been underway for several years, and gained new impetus following the 2007 release of the legislative study on brain injury services by the Joint Legislative Audit and Review Commission (JLARC) mentioned earlier. JLARC cited the DRS Central Registry as not being as effective as it could be in providing outreach to individuals who sustain such injuries and recommended that DRS reevaluate the system and explore more effective outreach methods. JLARC also noted problems with the compliance of some hospitals, particularly two Level I Trauma Centers, in reporting to the DRS Registry, although these same hospitals reported to the Virginia Department of Health's (VDH) Web-based Virginia Statewide Trauma Registry (VSTR).

Legislation was pending in the 2008 General Assembly both to repeal the *Code of Virginia* section establishing the DRS Virginia Central Registry for BI/SCI and to direct the Department of Health to share all VSTR information on patients with brain injury and spinal cord injury with DRS for outreach and programmatic purposes. This change, if approved, will likely result in a decrease in annual outreach numbers because the VSTR includes only those persons admitted to the hospital, and not those previously counted who were "treated and released" from the emergency room (typically people who have a concussion or "mild" brain injury). Through information received from VSTR, however, DRS will be able to provide critical outreach information on available services and resources to individuals with the greatest need for long-term services and supports (i.e., people with moderate to severe brain injuries). DRS has asked the Brain Injury Association of Virginia (BIAV) to study more effective outreach methods so that DRS will be poised to work with BIAV and other advocacy and service provider groups to get needed information to Virginians with brain injury, regardless of the outcome of the legislation.

The Woodrow Wilson Rehabilitation Center (WWRC) **Brain Injury Services (BIS) Department** Manager reports annually to the DRS Commissioner on program operations and outcomes. Internal WWRC processes govern program capacity and resource allocation, and

guidance on BIS activities is solicited from other management teams in the agency, as well as from community partners and stakeholders. Monthly meetings of the WWRC Brain Injury Team (BIT) review consumer satisfaction surveys, evaluate program data on numbers served and outcomes, and discuss program issues and concerns. Service Delivery and Summary Reports of outcomes data are shared monthly with the Division and Facility Directors, and substantive issues needing attention are shared with them as needed. The BIS Department Manager serves as a state agency representative and nonvoting, advisory member of the Virginia Brain Injury Council and reports at least quarterly to the Council on WWRC programs and activities. Links are also maintained with the Brain Injury Association of Virginia 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 described previously.

The **WWRC Medical Division's Compliance Program** provides oversight of services provided by the BIS Department and the Spinal Cord Injury Services (SCIS) program. Medical Division staff members are involved in auditing individual case records on a monthly basis to review admissions procedures, service provider documentation, medical coding, and billing practices. The Compliance Committee is responsible for overseeing this process, educating staff members on compliance issues, and providing quarterly reports to the WWRC Executive Team.

Case Management: Oversight for case management provided to persons receiving services under a Home and Community Based Medicaid Waiver, through the Program for All-Inclusive Care for the Elderly (PACE), or through publicly funded mental retardation services are discussed elsewhere in this section under those headings.

Responsibility for oversight of Department of Rehabilitative Services (DRS) **Community Rehabilitation Case Management (CRCM) Services** rests with its Program Manager and Division Director. Customer comments on the program are routinely documented, and concerns are forwarded to the appropriate Rehabilitation Specialist, Program Manager, and Assistant Commissioner, as needed. As a result of these comments, record reviews, and customer satisfaction surveys, areas needing improvement have been identified. Program policies have been updated, reporting mechanisms are being enhanced, and an improved mechanism evaluation by individuals with disabilities is forthcoming.

Comprehensive Services Act (CSA): The organizational structure and oversight provisions of the CSA are quite complex and cannot be covered in full detail in this report. The basic structure of oversight is provided below.

State-level oversight consists of a two-tiered, multiagency system. At the highest level, the **CSA State Executive Council (SEC)** is chaired by the Secretary of Health and Human Resources, or designee. Other members includes representatives of the General Assembly, the Supreme Court of Virginia, a variety of State agencies, local government representatives, public and private providers, a parent, and the Chair of the **State and Local Advisory Team (SLAT)**. The SEC oversees the interagency cooperation and collaboration necessary to implement CSA at both the state and local level. It appoints members of SLAT, establishes appropriate policies,

oversees the use of CSA pool funds, and advises the Governor and Cabinet Secretaries on proposed policy and operational changes.

The **Office of Comprehensive Services (OCS)** serves as the SEC's administrative body. It ensures that SEC policies are carried out and provides policy development, fiscal management, data collection and management, information, and oversight for localities. OCS coordinates technical assistance, resources, training, best practices dissemination, and management reports to support community CSA systems. OCS provides utilization management services of some residential programs when requested by localities. It partners with CSA stakeholder organizations, including family organizations, to improve the performance of CSA, and it works with localities and other state agencies to ensure compliance with CSA policies. OCS also maintains an authorized provider database.

The OCS staff conducts both routine and special compliance reviews of local CSA operations. These reviews can be on- or off-site and are used to identify training and technical assistance needs as well as the overall level of statewide compliance with requirements. If program-specific concerns are identified, staff members from appropriate agencies may be called in to assist in the review process. Following a review, a summary is provided to the Community Policy and Management Team (CPMT) Chair and shared with others as appropriate. This report contains information collected during the review, requests a corrective plan for any areas needing remediation, and makes recommendations for training or technical assistance when appropriate.

The State and Local Advisory Team (SLAT) 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 SEC on matters related to CSA administration, interagency collaboration, technical assistance, and policy, and it operationalizes SEC decisions.

At the local level, municipal governments have considerable flexibility in designing and delivering services under the CSA. A two-tiered system involving a Community Policy and Management Team (CPMT) and a Family Assessment and Planning Team (FAPT) is required by Virginia law. Localities must have a system in place for review of case data (e.g., diagnoses, reason for services, referrals) and program information (e.g., service delivery, quality, and costs) to ensure that services are appropriate, cost effective, and provide the best possible outcomes for at-risk youths and their families and that local government is in compliance with CSA policies and procedures. The reviews also identify local technical assistance, training needs, and policy issues requiring attention at the state and local levels. Within accountability guidelines established by the SEC, localities retain a great deal of latitude in designing individual utilization management systems that best fit their situations.

Despite this comprehensive system of monitoring and evaluation, considerable concerns remain regarding the CSA program. The 2006 General Assembly established a subcommittee to study the cost effectiveness and administration of CSA and directed the Joint Legislative Audit

and Review Commission (JLARC) to evaluate the program and make recommendations for program improvements and for cost containment strategies.

The JLARC report, *Evaluation of Children's Residential Services Delivered through the Comprehensive Services Act*, published in 2007, 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. Most of these nearly 300 licensed residences were found to be concentrated in only a few regions of the state, at lengthy distances from the children's families and home communities. Gaps in community services were noted as a significant contributing factor in having to serve children in residential facilities even when such settings were "unnecessarily intensive or unduly restrictive." Moreover, 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 is engaged in a number of initiatives to address the issues and recommendations made by JLARC. To reduce overreliance on residential services, OCS has made available competitive Innovative Community Services Grants to localities, \$250,000 in Fiscal Year 2007 and \$500,000 in FY 2008. These grants will encourage development of services to prevent the need to serve children in residential programs and enable youths already in residential programs to return to communities when they can be served effectively there. OCS also is working to strengthen local CMPTs and FAPTs by developing and distributing Virginia best practice models for policy guidelines, assessment tools and skills training, planning, and systems coordination. Improved systems for tracking outcomes are also under development, as are various other training and technical assistance activities including development of a System of Care Academy and use of incentives to reduce the provision of services and length of stay in residential programs.

Other initiatives to improve CSA include work in the foster care arena through the First Lady's "For Keeps" Initiative focused on improving foster care and reducing reliance on residential care. Numerous budget items pending before the 2008 General Assembly address increases in funding to serve more children, increase foster care payment rates, and offer financial incentives for localities and providers to keep children in their communities. A new demonstration waiver is also underway, administered by the Department of Medical Assistance Services (DMAS) to help Medicaid-eligible children in psychiatric residential treatment facilities receive community-based mental health services and family supports.

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 both their individual governing boards and with the Department of Rehabilitative Services (DRS). Accountability is maintained by CIL Executive Directors, by individual governing boards, and by the DRS Office of Independent Living. Statewide monitoring by the DRS Independent Living Office includes site visits, reports, and monitoring of plan services of each Center for Independent Living. CILs submit quarterly and yearly reports and financial audits

Outcomes of CIL services are evaluated on a regular basis. The evaluation format includes quarterly reporting of progress in achieving program activities, tracking of local and statewide training for Center Staff members and individuals with disabilities, and recording systems change measures at the local and state level. Examples of the latter include increased access to Home and Community Based Services Waiver programs, increased transportation services, and expanded housing options. Outcomes are also monitored through tracking the number of individuals who have transitioned out of nursing facilities and those who are able to avoid entering nursing homes.

Since core services are provided by CILs through a consumer-directed service model, feedback from individuals with disabilities receiving services is a crucial part of service implementation and evaluation. All CILs obtain feedback from consumers 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 CIL staff. A report of the survey results is submitted to the respective CIL Executive Directors and Boards with recommendations for service improvements, changes, or additions.

Department for the Blind and Vision Impaired (**DBVI Rehabilitation Teaching and Independent Living (RT/IL) Services**) are overseen by a Program Director assisted by six Regional Managers who directly supervise DBVI services. Periodic performance evaluations of rehabilitation teachers and the RT Program Director are used to maintain accountability for RT programs. The Regional Managers and RT Program Director also review case records and accompany Rehabilitation Teachers in the field to monitor services for effectiveness. In addition, representatives from the DBVI central office conduct annual case reviews in each of the regional offices, and feedback on services is solicited from customers and persons with disabilities. Corrective actions resulting from these reviews may result in additional staff training, casework corrections, or other personnel actions. The RT/IL Program Director may also modify the policy manual or arrange for general staff training to increase the effectiveness of a program.

The 2007 DBVI 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, has a negative impact on client skill acquisition. To reduce caseload size from an average of 46 to 32 persons, DBVI successfully submitted a budget amendment to the General Assembly for additional Rehabilitation Teachers. Although the legislature approved funding for seven new teaching positions in the Fiscal Year 2008 budget, only one of those positions was filled because of the statewide revenue shortfall in the autumn of 2007. DBVI continues to investigate strategies to improve service delivery and reduce the administrative burden on the staff, thus increasing the time available for direct services to individuals. The use of telework and plans to implement a new case management system in 2008 are potential methods being considered to streamline service delivery.

Quality assurance procedures for **DBVI DeafBlind Services** and **Low Vision Services** parallel those described above for RT/IL Services. In addition, the Low Vision Program Director

has responsibility for hiring, training, and monitoring the low vision examiners contracted to provide services for DBVI customers. Periodic performance evaluations of these examiners are reviewed by regional office staff members and the Low Vision Program Director, and if examiners are found to be noncompliant with DBVI policies and practices, their contracts may be cancelled. Feedback on these and other DBVI services, such as the **Older Blind Grant** and **Vocational Rehabilitation** programs, is also obtained through periodic customer satisfaction surveys.

The 2007 DBVI Agency Strategic Plan reports completing the first year of a new three-year initiative to improve data collection and case management services. In partnership with the Department of Rehabilitative Services, DBVI has underway the Integrated Case Management (ICM) project, which includes integration of new software with online office tools that will improve client tracking as well as case service authorization, budgeting, and planning.

Omnibus Budget Reconciliation Act (OBRA): Responsibility for oversight of OBRA services rests with the Department of Rehabilitative Services (DRS) Division Director and Program Manager. OBRA services must comply with federal regulations. DRS maintains performance measures that relate directly to OBRA administration under a Contractual Agreement between the agency and the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS). Customer comments are routinely documented, and concerns are forwarded to the Program Coordinator, the appropriate Rehabilitation Specialist, and the Division Director, as needed. Consultation with the DMHMRSAS liaison for OBRA is maintained on an ongoing basis. State agencies report that the OBRA program has continued to make revisions and programmatic changes, including providing more access to rehabilitation engineering and specialized services. This has reportedly increased overall consumer satisfaction.

Outreach, Training, and Technical Assistance: Oversight of Department for the Deaf and Hard of Hearing (DDHH) **Outreach Services** is the responsibility of the Program Manager and agency Director. Although Outreach is not a regulated program, the agency's Executive Agreement includes several related performance measures. In addition, Outreach provider contracts contain specific performance targets and strict reporting requirements that are carefully reviewed by the VDDH staff on a regular basis. Contractors who do not meet requirements are offered a corrective action plan. If they continue to fall short, contracts can be cancelled and rebid.

The DDHH Program Manager and agency Director also provide oversight for **Interpreter Services** and the **Virginia Quality Assurance Screening (VQAS)** program, which are regulated programs. These programs, too, have specific performance measures regarding program administration in the agency's Strategic Plan. The Program Manager routinely reviews program statistics and customer feedback as part of an ongoing informal evaluation process. If a complaint is received about a nationally certified interpreter assigned by DDHH, the agency recommends that the person reporting the complaint file a formal complaint with the certifying

body (usually the Registry of Interpreters for the Deaf, Inc.). Depending on the outcome of that formal complaint, VDDHH may consider canceling the contract in accordance with the provisions of the contract. If the complaint involves a VQAS-screened interpreter, the interpreter is called in for a counseling session to review the Code of Ethics and other contract requirements. If the situation cannot be resolved, the agency may cancel the interpreter's contract in accordance with the provisions of the contract.

DDHH uses the VQAS diagnostic and proficiency screening instrument to assess the knowledge, skills, and abilities of interpreters and other professionals who facilitate communications for individuals who have hearing or speech impairments. The VDDHH Program Manager regularly prepares Rater Report Cards to ensure interpreter consistency and effectiveness. Raters receive annual training, and if a rater falls outside of expected performance standards, retraining is provided. Feedback from individuals with disabilities is received through the DDHH Outreach program.

Personal Assistance Services (Non-Waiver): The state-funded personal assistance services, **State PAS and PAS for Individuals with Brain Injury**, are overseen by the **Department of Rehabilitative Services (DRS) Community Based Services Division** Director and Program Manager. Quarterly meetings to discuss the programs and make recommendations for improvement are held by a PAS Advisory Committee comprised of individuals with disabilities, Centers for Independent Living (CILs), PAS Coordinators, and agency representatives. Feedback is garnered from satisfaction surveys, as well as from members of the PAS Advisory Committee. Program improvement goals are identified from internal record reviews and through contacts with individuals with disabilities, personal assistants, families, and the CILs. Feedback gathered from the committee and through records' review and feedback is implemented as appropriate. DRS internal program audits are also conducted and these recommendations are implemented. Recent updates have been made to PAS program policies, the Consumer PA Handbook, and various program forms.

Publicly Funded Mental Retardation (MR) Services: As the state authority for intellectual disability (mental retardation) services, the **Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS)** is accountable for licensing private programs and providers of MR (intellectual disability) services, providing human rights' oversight, furnishing technical guidance, conducting operational and fiscal oversight, budgeting and allocating funds for system agencies, and conducting and overseeing quality assurance activities. These responsibilities include oversight for the program, fiscal, and administrative activities of the state's 40 local **Community Services Boards (CSBs)**, and five state-operated Training Centers.

DMHMRSAS requires CSBs to operate according to an annual Community Services Performance Contract that defines specific roles and responsibilities with regard to state and federal service requirements for service delivery. Numerous instruments, data, and mechanisms for oversight of contractual requirements are set forth in the Fiscal Year 2008 Performance Contract. This accountability tool, signed by the Commissioner and the CSB Executive Director,

takes a quality improvement approach to performance and compliance issues. The Central Office, State Facility, and CSB Partnership Agreement incorporated into the contract defines system values, establishes a collaborative operational partnership among participants, delineates roles, and identifies processes for improving the quality of care throughout the DMHMRSAS public service system. In addition to DMHMRSAS oversight, CSBs are guided and administered by local Boards of Directors that consist of 6 to 18 members appointed by local government bodies.

The DMHMRSAS Office of Community Contracting, as the office primarily responsible for negotiating and monitoring the Performance Contract, works with the other DMHMRSAS offices in monitoring CSB compliance with various provisions in the contract. DMHMRSAS offices conduct and document monitoring activities pertaining to specific contract requirements. On-site reviews of CSB consumer records and fiscal documents are identified as monitoring mechanisms for a number of performance expectations; according to DMHMRSAS, however, limited staffing makes it challenging to conduct these reviews. When such reviews do occur, they typically target CSBs with pervasive or repetitive compliance problems. When compliance issues or deficiencies are found, DMHMRSAS attempts to address or resolve them initially through informal and then formal mechanisms (e.g., discussion, negotiation, exchange of correspondence, or corrective action plans). If these efforts are not successful, other resolution mechanisms in the Performance Contract can be used, and as a rare and last resort action, state funding can be withdrawn from the applicable service or program.

DMHMRSAS licensing policies and procedures, which cover hundreds of additional service providers, require adherence to state regulations established by the agency. The **DMHMRSAS Office of Licensing (OL)** provides oversight for providers of treatment, training, and habilitation for individuals with mental illness, intellectual disability (mental retardation), or substance abuse disorders, including those who receive services under the Individual and Family Developmental Disabilities (DD) Waiver. Licensing staff members are required to make at least one unannounced inspection of a provider each year and to investigate complaints against providers. In addition, OL staffers train new providers, provide ongoing technical assistance to all providers, and have responsibility for prior authorization of services and supports.

The scope of work for the DMHMRSAS Office of Licensing (OL), as the data in the table below indicates, continues to grow at a significant rate. From Fiscal Years 2005 through 2007, both the number of licensed providers and services increased by 16 percent; and the number of service locations increased by 11 percent. During this same period, there has been limited funding for new positions, and there has been no growth in the provision of training, technical support, and service authorization.

DMHMRSAS LICENSED PROVIDERS, SERVICES, AND LOCATIONS

Category	2005	2006	2007	Change	
				Number	Percent
Licensed Providers	457	481	529	72	16%
Licensed Services	1,084	1,175	1,257	173	16%
Licensed Locations	2,684	2,764	2,970	286	11%

Sources: 2005 and 2006: Office of Licensing *Annual Report, FY 2006*;
2007: DMHMRSAS, December 19, 2007.

The **DMHMRSAS Office of Human Rights (OHR)** is responsible for ensuring protection of the legal and human rights of individuals receiving service in state facilities and the community-based programs that the Department operates, licenses, or funds (excluding those operated by the Department of Corrections). The OHR monitors compliance with human rights' regulations, promotes the basic precepts of human dignity, advocates for the rights of persons with disabilities, and manages the DMHMRSAS Human Rights' dispute resolution program. The *Code of Virginia* (§ 37.2-400) enumerates the rights of recipients of institutional and community services that are funded or licensed by DMHMRSAS.

Created in 2000 by *Code of Virginia*, § 37.2-423, the **Office of the Inspector General (OIG) for Mental Health, Mental Retardation and Substance Abuse Services** is required to "inspect, monitor, and review the quality of services provided" by state facilities and public or private entities or organizations that provide community services to persons with intellectual disabilities (mental retardation), mental illness, or substance abuse disorders. The Inspector General for MHMRSAS is appointed by the Governor, subject to confirmation by the General Assembly, for a four-year term that is not coincident with the Governor's term. Until 2005, at which time the General Assembly increased OIG funding, the focus of inspections was on services at state mental health and mental retardation facilities.

OIG oversight of community services specifically includes day support, in-home support or crisis stabilization services funded through the DD Waiver, services provided under the 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. The OIG is authorized to make announced and unannounced site visit inspections of providers for the purpose of preventing problems or deficiencies and improving service effectiveness; in addition, it routinely monitors serious incident reports as well as reports of abuse, neglect, or inadequate care by providers. The Inspector General must keep the Governor, General Assembly, and Joint Commission on Health Care fully informed of both significant problems or deficiencies and recommendations for corrective actions and must prepare and deliver semiannual reports of activities that summarize such information. These reports are available to the public at the OIG's Web site.

Recent studies addressing issues affecting persons with intellectual disabilities conducted by the OIG include a *Review of Community Residential Services for Adults with Mental*

Retardation and, most recently, a *Review of Community Services Board Mental Retardation Case Management Services for Adults*. The latter, conducted in May and June 2007, was based on a self-administered survey of all 40 community services boards (CSBs), site visits that included staff interviews at a random sample of 28 CSBs, a review of 275 service recipient case records, and interviews with 26 private residential service providers and 92 randomly selected family members or authorized representatives of individuals receiving MR case management services. None of the 14,000 actual case management service recipients were interviewed. Services were reviewed on the basis of five Quality Statements developed by the OIG in collaboration with stakeholders.

The review resulted in a large number of findings and recommendations regarding CSB case management services. Complete findings are detailed in the OIG Report that can be found on the OIG Web site. Examples listed below indicate both the strengths and challenges of the current case management service system:

- An estimated 12 percent of the 13,083 adult case management recipients do not qualify for Medicaid and are, therefore, ineligible for Medicaid-funded targeted case management. Nonetheless, they receive the same level of case management services as CSB clients covered by Medicaid. These adults, however, have less access to other important services that Medicaid covers (e.g., outpatient therapy, transportation, basic health care, and affordable medications).
- The average frequency of face-to-face contact with clients by CSB MR case managers, 2.2 times per quarter, exceeds Medicaid standards. The average range was 1.1 to 4.4 contacts per quarter.
- Persons receiving CSB MR case management services faced “severe shortages of core services needed for successful integration and independence in the community.” Choice is limited by scarcity of varied service options.
- CSB case managers encounter significant difficulty in obtaining therapy and psychiatric services for clients who have co-occurring MR and mental illness or behavioral challenges.
- While a majority of CSB MR case managers had job tenure that enabled continuity with their clients, 26 percent had been on the job 12 months or less. While the average tenure was 5.9 years, the most frequently occurring tenure was only 1 year. Turnover among the case managers varied significantly among CSBs.
- Salary ranges for MR case managers at some CSBs are very low. This contributes to staff turnover that exerts a negative impact on continuity of care. Compared to the average salaries of starting and experienced schoolteachers, average case manager salaries are significantly lower, with the gap greatest for experienced managers.

In order to improve case management for persons with intellectual disabilities, the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) has initiated a number of activities to be implemented during 2008. For

example, the DMHMRSAS Person-Centered Practices Leadership Team, in collaboration with other stakeholders, is developing a document of new processes and tools that will both ensure compliance with regulatory standards and lead to positive, person-centered outcomes for persons with intellectual disabilities. In collaboration with the Virginia Association of CSBs and the State Mental Retardation Council, DMHMRSAS has asked the CSBs to identify service gaps for persons with co-occurring MR and mental illness or challenging behaviors and develop a plan to address those gaps by December 31, 2008. In addition, during 2008, a study will be conducted of issues raised by the OIG, such as case manager salaries, caseload sizes, and documentation expectations, among others.

Services to Virginians Who Are Elderly: The Virginia Department for the Aging (VDA) provides quality assurance for services provided by Virginia's 25 **Area Agencies on Aging** and other contractors. Service standards for the AAAs are posted on VDA's Web site for easy reference. These standards cover record-keeping, appeals processes, federal and state laws, medication management, the use of the Uniform Assessment Instrument, and other program-specific criteria. VDA monitoring includes both fiscal and program reviews as well as on-site technical assistance when needed. Contractors may be required to prepare and implement a corrective action plan when deficiencies are noted. VDA also periodically evaluates the social, physical, and economic needs of older Virginians to determine the extent to which public and private programs are meeting those needs.

The Public Guardian and Conservator Advisory Board works with VDA to provide oversight for Virginia's **Public Guardianship and Conservator Program**. Created by *Code of Virginia*, § 2.2-2411, this board consists of 15 members appointed by the Governor from specific organizations. The board provides guidance to the VDA Commissioner on public guardianship and also assists in the coordination and management of local public guardianship programs.

The VDA has statutory responsibility (*Code of Virginia*, § 2.2-704) for receiving, investigating, and resolving complaints concerning community long-term care services made by or made on behalf of elderly recipients whether those services are provided by state agencies, AAAs, or any private or nonprofit agency. In collaboration with regulatory agencies and programs such as Adult Protective Services, the VDA **Long-Term Care Ombudsman Program** focuses on nonadversarial complaint resolution "and empowering persons to resolve complaints themselves when appropriate." In addition, this program provides consumer education, advocacy, and information and referral services. The VDA contracts with the Virginia Association of Area Agencies on Aging (VAAAA) to operate this program and with 21 AAAs to provide local ombudsman services. VDA operates a toll-free hotline linked to the program to ensure coordinated statewide access and requires program staff members to complete a certification curriculum.

The Department for the Blind and Vision Impaired (DBVI) Rehabilitative Teaching and Independent Living (RT/IL) Program Director is responsible for oversight of the **Older Blind Grant Program**, which is conducted with the assistance of the six DBVI Regional Managers who directly supervise RT staff. DBVI contracts with Mississippi State University to provide an

annual program performance evaluation. The university conducts a customer satisfaction survey using a random selection of all individuals who have received services and also makes an on-site visit to observe Rehabilitation Teachers working with Older Blind Grant customers. In addition, DBVI Regional Managers and the RT/IL Program Director review case records and accompany Rehabilitation Teachers in the field to observe their effectiveness in providing services.

The DBVI Central Office performs random case reviews in each regional office during the year and solicits feedback from customers and service recipient groups. An annual report is submitted to the federal Rehabilitation Services Administration (RSA) that is responsible for the grant program. If RSA finds the program to be noncompliant, DBVI is required to submit a corrective plan indicating the actions to be taken and their completion dates. The RT Program Director can also recommend adjustments to the policy manual or propose staff training to increase program effectiveness. Performance reviews by local supervisors may lead to individual training, casework corrections, or other personnel actions.

State regulation (12VAC30-120-62) tasks the Department of Medical Services (DMAS) with primary responsibility for oversight of **Program for All-Inclusive Care for the Elderly (PACE)** services. Whenever an entity is selected in response to a Request for Applications to be a PACE provider, DMAS conducts a PACE Plan feasibility study to determine whether the entity has the ability and resources necessary to operate a PACE plan effectively. DMAS can only contract with those providers for whom a positive determination was made. Each PACE provider must meet all conditions of participation required by the Centers for Medicare and Medicaid Services (CMS) pursuant to 42 CFR, Part 460, and meet state statutes (*Code of Virginia*, §§ 32.1-330.2 and -330.3) as well DMAS regulations, policies, and procedures. Other plan requirements, including minimum staff qualifications among others, are described in 12VAC30-120-62.

Prior to program implementation, DMAS conducts onsite reviews and **State Readiness Reviews (SRR)** of each PACE program. Training is provided to all preadmission screeners in the localities within the PACE coverage area. Following program implementation, DMAS conducts quarterly **Quality Management Reviews (QMRs)** of each PACE program. CMS, in collaboration with DMAS, also conducts an On-site Review and Evaluation of each PACE program. During all on-site reviews and QMRs, a thorough review of all PACE processes and procedures, care plans, and participant medical records is completed 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 of each PACE program to gather information regarding various program features, such as enrollment procedures, information sharing, and participant care. DMAS has the ability to retract Medicaid payments or terminate the provider agreement, or both, if noncompliance of a provider is significant enough to warrant such action.

Service System Planning: Local **Disability Services Boards (DSBs)** are responsible to the governing bodies of the localities that they represent and advise. A statewide Disability Services Council (DSC), established under § 51.5-49 of the *Code of Virginia*, provides oversight for DSB

reporting, is responsible for the annual distribution of Rehabilitative Services Incentive Funds (RSIF), and provides a final review of requests for proposals for RSIF awards. The DSC is composed of the Commissioners of the Department of Rehabilitative Services (DRS) and the Departments for the Blind and Vision Impaired (DBVI) and Deaf and Hard of Hearing (DDHH), the Superintendent of Public Instruction (DOE), three individuals with physical and sensory disabilities, and one representative from local government. The local government representatives and the individuals with disabilities are appointed by the Governor for three-year terms, and the Governor appoints the council's chairman annually.

As noted in the report, *Disability Services Boards System Evaluative Review, 2007*, DRS has increased oversight and technical assistance to DSBs over the past three years. In 2005, the DRS Commissioner hired a full-time Program Manager in the state DSB office who is dedicated to training, technical assistance, and monitoring of the DSB system. In 2007, an automated annual reporting system was developed that will provide data on outcomes and activities on a quarterly and annual basis, and a new process of formal audits by the DRS Fiscal Office on DSBs and grant recipients was implemented.

Oversight for the **Statewide Independent Living Council (SILC)** rests with the Governor, who appoints its members, and the federal Rehabilitation Services Administration (RSA). The SILC must submit a three-year State Plan for Independent Living and subsequent annual reports to the federal RSA. SILC self-evaluations are used by the RSA to monitor and approve plan implementation on an ongoing basis. Corrective options open to the RSA, should they be necessary, include removal of Title VII Part B funds for independent living.

G. Areas of Concern about Community Living Supports

The chapter detail provides information on services and supports available to persons with disabilities through a variety of agencies and programs. As noted in the introduction, the content is not all-inclusive, nor is the information about each program and service completely comprehensive. For additional, more-detailed information, the reader can refer to the agency and program reports available on the Internet or in the resource list at the end of the chapter. Cited throughout the chapter are important statistical data regarding program activities and performance indicators. The chapter detail also provides information on areas in which the system and services have improved and describes improvement activities and outcomes. Section G focuses on the specific areas in which further improvements may be needed to move the system forward and ensure that the needs of eligible infants and toddlers with disabilities throughout the Commonwealth are met. The Virginia Board for People with Disabilities (VBPD) identified the issues and concerns below through a variety of mechanisms, including: (1) review and analysis of the numerous source documents referenced within and listed at the end of this chapter, (2) public comment received via VBPD's six public forums held throughout the state in the spring of 2007, and (3) written comment and information provided and verified by state agencies in their reviews. The issues below are not all-inclusive, but represent those that the Board has identified as important to systems improvement.

Community living supports are paramount for VBPD because community inclusion is the predominant focus of the Developmental Disabilities and Bill of Rights Act of 2000 under which the Board is authorized and funded. VBPD has invested hundreds of thousands of dollars and has partnered with state and local agencies as well as private organizations to develop and/or facilitate creative community living options and services and supports for people with developmental disabilities. As the issues below demonstrate, however, much more work is needed to move the system forward.

- 1. Fragmentation of Disability Services System:** As described in the *2006 Biennial Assessment* and this chapter, service fragmentation remains problematic. Services to persons with disabilities continue to be administered in highly compartmentalized systems at both the state and local levels. There is no overarching, person-centered or life-span organization in the state system designated for persons with developmental and other disabilities. Service “silos” exist, in part, because many state agencies have a specific disability constituency determined by diagnosis. Some agencies serve the entire spectrum of disability diagnoses, but have a narrow service mandate, e.g., provision of vocational rehabilitation services. In addition, state agencies that do not have a disability focus often lack information, knowledge, and experience with regard to the needs of persons with disabilities, and do not include them in their planning. While the system remains unchanged at present, there is a growing recognition by policymakers that Virginia’s historical definitions of disability and provision of services within specific service silos based on disability or type of service is a contributor to service and planning fragmentation. As noted in this chapter, a growing number of positive initiatives are underway to improve comprehensive, integrated planning for persons with disabilities. Prominent examples include, but are not limited to, the Systems Transformation Grant, the Money Follows the Person initiative, and recent studies such as the MR Waiver Systems Study and the efforts conducted by the Joint Commission on Health Care’s Workgroup on Autism.
- 2. Lack of a Developmental Disabilities “System”:** As reported in 2006 and unchanged at present, unlike individuals with a diagnosis of intellectual disability (mental retardation), people with developmental disabilities do not have a “home,” i.e., a dedicated funding stream and service system to meet their needs. Virginia, unlike other states that have a more inclusive system of services, does not have a state entity designated with responsibility for policy development, service planning, or service provision regarding those with developmental disabilities. Despite implementation of the Developmental Disabilities (DD) Waiver and Department of Mental Health, Mental Retardation and Substance Abuse (DMHMRSAS) training efforts on person-centered planning, the current service system still lacks a person-centered focus and a life-span design regarding persons with developmental disabilities who do not have a concurrent diagnosis of intellectual disability. Thus, the service system fails to identify, account for, or plan for the needs of numerous individuals because the nature or severity of their disability does not fall within traditional definitions and the established service system structure.

In response to the 2007 passage of House Resolution No. 60, the Joint Commission on Health Care Behavioral Subcommittee began to study the issue of a “home” for Autism. This discussion was expanded to Developmental Disabilities as a whole. A workgroup was formed that included advocates and family members as well as representatives from various state and local agencies. The result was budget language by the Joint Commission asking the Secretary of Health and Human Resources to develop an implementation plan to determine the state agency that should be responsible for autism services or developmental disability services as a whole. The Governor’s budget for the 2008–2010 Biennium has proposed a position at DMHMRSAS to address autism services. Another proposed legislative study seeks to examine best practices in autism as well as training for law enforcement personnel.

- 3. Institutional Bias of Disability Services System:** Virginia continues to spend a disproportionate amount of funding on institutional versus community-based services and has lagged behind most of the rest of the nation in its funding for community services. Virginia continues to be ranked among the lowest of all the states in community Medicaid expenditures across several indicators, although we have moved from 48th in FY 2005 to 46th in FY 2007. Virginia is behind many other states in the development of critical community-based living and support options for persons with developmental disabilities, enabling few real choices for persons who would choose to live in the community if services and supports were available.

The aging and condition of state Training Centers also remains a major concern, since the “youngest” facility is more than 30 years old and two others have substantially older buildings in use. The *2007 Study of the MR Service System* proposes a major state commitment for funding of MR Waivers and community services, including residential options, over the next four biennia; it also continues a commitment, however, to renovate the aging facilities. Over time, renovation costs at these and other state facilities are likely to increase. Given the finite nature of state revenue, renovations will have a negative impact on the moneys available for community services.

In addition to concerns expressed by parents whose children reside in the Training Centers, as elsewhere, the emphasis on maintaining institutions continues to be driven, in part, by the economic and political concerns that eliminating the state Training Centers would damage the economy of the community in which each is located. The more likely reality is that jobs will continue, but with a change in the location of services. Moreover, building community infrastructure will result in expanded employment opportunities for localities statewide. While the Commonwealth’s philosophy and intent is to develop community infrastructure and supports, significant political support is needed to refocus Virginia’s effort on community versus institutional infrastructure.

- 4. Continued Growth of MR and DD Home and Community Based (HCB) Waiver Waiting Lists:** The Medicaid HCB Waiver has become the principal, if not the only, source of funding for community supports for many families. Incremental yearly funding increases for Waiver slots continue to be the norm, while need and the waiting lists grow. DMHMRSAS estimates that the wait list for Mental Retardation (MR) Waiver has grown by one person per day since FY 2004; and found that the average length of time on the MR Waiver Waiting

List is 28 months, but for some individuals it is as high as 7 years. Neither the MR nor Developmental Disabilities (DD) Waiver Wait lists may reflect true need, however. While it is clearly not the policy of DMHMRSAS, the Board frequently hears comments from families discouraged by local agencies from applying for a waiver slot because of the long wait; others may simply be unaware of potential eligibility for Waiver services.

An additional concern regarding the MR Waiver Wait List issue is that persons residing in nursing facilities and small ICFs-MR cannot be placed on the Urgent Waiting List and are not listed on the nonurgent list, because their health, safety, and welfare needs continue to be met while institutionalized. At least one advocacy organization opposes the allocation of adding facility residents to the Urgent Waiting List since it will increase that list's size and, according to the organization's public comment, place facility and community residents in competition with one another for limited slots. VBPD agrees that the solution is adequate funding of Waiver slots for those on the waiting list. Under the current system, however, persons in institutions have little hope of ever living in the community with the needed services and supports that would be provided under the MR Waiver. A review of the outcome of the Money Follows the Person demonstration initiative will prove extremely helpful in determining how best to proceed in this area.

5. **Growth of Non-Waiver Program Wait Lists:** While the political and advocacy focus is primarily on the Home and Community Based (HCB) Waiver Waiting Lists, those lists also exist for other community-based services. Examples of programs with waiting lists include, but are not limited to: the Community Rehabilitation Case Management Program and the Personal Assistance Services (PAS) Program, both administered by the Department of Rehabilitative Services. Sufficient funding for these programs would provide critical community supports for persons who are on a waiver waiting list or who are not eligible for a waiver, but require a level of support to live successfully in the community. It should be noted that some programs do not maintain waiting lists, making it difficult to assess and plan for actual funding and program needs.
6. **Need to Examine Home and Community Based (HCB) Waiver Waiting List Administration/Slot Allocation:** Administration of HCB Waiver Waiting Lists has become an issue of considerable controversy. The Developmental Disabilities (DD) Waiver has statewide administration with emergency slots available. In its *2006 Biennial Assessment*, the Virginia Board for People with Disabilities (VBPD) recommended statewide administration of the Mental Retardation (MR) Waiver Waiting Lists rather than the current system of local determination of MR Waiver slot distribution. This 2006 VBPD recommendation was made to address concerns regarding variation between localities in a person's access to and waiting period for the MR Waiver and widely divergent local practices; and ensure that the limited MR Waiver slots went to those with the most urgent needs first, regardless of the locality in which they resided. The VBPD 2006 recommendation provoked considerable opposition from the Virginia Association of Community Services Boards (VACSB), from the Arc of Northern Virginia, and the Arc of Virginia. Public comment from these entities to the Board in 2007 posited that the current

allocation system works well, and that localities are best able to determine the needs of their residents.

There is definitely strong disagreement among advocates on this issue. VBPD believes, however, that no issue should be “off limits” and that issues of fairness and equity across the state remain. There should be, and must continue to be, open dialogue on this and other controversial issues associated with providing the best services possible to mutual consumers.

7. **Lack of Choice in Case Management for MR Waiver Recipients:** In its *2006 Biennial Assessment*, the Board brought forth the issue of ensuring choice under all HCB Waivers for all services, including case management. VBPD noted that the difference in choice under the Developmental Disabilities (DD) Waiver versus the Mental Retardation (MR) Waiver represents an equity issue for individuals receiving services under the MR Waiver who do not have the opportunity to choose a case management provider from outside of the Community Services Board (CSB) system.

The VBPD recommendation for full choice of case management providers for MR Waiver recipients resulted in extensive dialogue and significant opposition from several entities, including the Virginia Association of Community Services Boards, the Arc of Northern Virginia, and the Arc of Virginia. On the other side of the issue are the Centers for Independent Living and Autism/DD advocates statewide who believe that choice in case management is an essential protection for families and a right under the HCB Waiver system. In addition to public comment received by VBPD, the issue of choice in case management was a source of considerable discussion at the 2007 Joint Commission on Health Care’s Workgroup on Autism, during which DD and Autism advocates and family members opposed Waiver or service consolidation unless choice was maintained. VBPD respects the differing opinions on the issue but believes it is a disservice not to bring forth issues in which further examination is both desirable and important.

8. **Concern over Organizational Conflict of Interest:** In its *2006 Biennial Assessment*, the Virginia Board for People with Disabilities (VBPD) reported that public comment in a variety of arenas indicated that the multiple roles some community service boards (CSBs) have for planning, screening, referring, providing, funding, and overseeing services can be problematic with potential bias in service provision or less rigorous oversight. Families have reported that they believe their family members are automatically steered to the services offered by their CSB. Other family members indicate satisfaction with CSB services and processes. Many individuals throughout the Commonwealth are clearly served very well through the CSB system. Regardless of the excellent intentions and work of CSBs’ Board members and staff, however, there is an inherent systemic conflict of interest whenever a single entity (whether private or public) is responsible for the multiple roles of determining initial and annual eligibility, providing case management, service planning, service delivery, service funding, and service oversight.
9. **Lack of Funding Stream for Individuals not Eligible for Home and Community Based (HCB) Waivers:** As addressed in the 2007 Department of Mental Health, Mental

Retardation and Substance Abuse Services (DMHMRSAS) *Study of the MR Services System in Virginia*, because of restrictive eligibility criteria (i.e., meeting ICF-MR eligibility), many individuals with developmental disabilities including, but not limited to, those with intellectual disabilities, are not eligible for HCB Waiver services and receive few or no community supports. The lack of a funding stream or of program-support options for these individuals is a serious gap in the service system that requires further study, analysis, and action. VBPD supports the DMHMRSAS study recommendation that General Fund dollars be committed to provide services and supports for these individuals.

10. **Inadequate Funding for Centers for Independent Living (CILs):** As entities required by federal statute to be both multidisability and peer-directed or -operated, Centers for Independent Living (CILs) are key resources for persons with disabilities residing in communities. Virginia has been more successful than other states in expanding CIL services and obtaining additional state funding for CILs. CIL activity is still limited, however, by relatively low funding levels (funding remains below the recommended national base [currently, \$250,000] for seven CILs or satellites) and gaps in geographic availability of CIL services, with some parts of the state completely unserved. Since FY 2005, new state funding has been provided to support CILs and two new satellite CIL centers opened in 2007. These increases are positive but have not met the demand as identified by the CIL budget requests and public testimony. Core and other services offered by Centers for Independent Living provide critical assistance to persons with disabilities and are strongly focused on consumer direction and self-determination.
11. **Inadequate Availability of Qualified Providers:** The availability of adequate numbers of qualified providers continues to exist. Demand for qualified, reliable direct care staff members continues to outstrip their availability. Low pay and reimbursement rates, lack of employee benefits, and a cumbersome payment system result in low numbers of individuals willing to enter or remain in the field as well as high rates of turnover between providers and recipients of the services. There is also marked disparity in regional availability of providers with Northern Virginia having fewer challenges than more rural areas of the state, which have severe shortages. A noted fiscal barrier for residential providers is the lack of funding for “general supervision.” A lack of respite providers was also cited as a key issue during the Virginia Board for People with Disabilities (VBPD) 2007 public comment events.

In 2007, the Governor’s Health Reform Task Force Final Report *Roadmap for Virginia’s Health* addressed numerous issues with respect to quality of care, access to care, and long-term care, among other related issues. The recommendation concerning access to a “seamless coordinated system of information and decision-making tools” and increasing the “availability and scope of integral services for seniors and person with disabilities” are extensive and are supported by VBPD. This report also contains an excellent description of the challenges of the direct care workforce and a number of recommendations regarding the nursing and direct support workforce that VBPD also supports.

12. **Low and Inconsistent Home and Community Based (HCB) Waiver Reimbursement Rates:** Low provider reimbursement rates continue to be an issue that inhibits both the growth of community-based services and supports and the development of new providers and

services. In particular, rates for personal care, respite, and skilled nursing services are too low to attract and maintain providers. Annual cost-of-living increases are needed but are not given to providers or to the HCB Medicaid Waivers. While some providers devote all or a portion of rate increases to direct salary increases for the staff, others utilize rate increases to cover increased administrative costs. While VBPD understands the need to cover the costs of operation, the argument for rate increases has historically been to hire and maintain a high-quality staff. It is logical, then, that a portion of any rate increase should be used for this purpose.

Another challenge is that rates are not tied to the level or intensity of support needs. Thus providers may not be willing to work with individuals who have more complex needs, particularly behavioral challenges. This also makes it challenging for persons with significant disabilities to “age in place.” A third challenge has been the variability of reimbursement rates by different agencies for the same service. As reported in the *2006 Biennial Assessment*, the reimbursement rate for supported employment paid by the Department of Rehabilitative Services (DRS) was significantly higher than that paid for this service under Home and Community Based Waivers. The 2008 General Assembly passed budget language that will remedy this longstanding issue as of July 1, 2008.

There was an attempt to pass budget language to remedy the disparity in case management rates paid under MR versus the DD Waiver but the language did not pass. The responsibilities are nearly identical, with the exception of one additional responsibility for DD case managers, but the DD case management is paid at a significantly lower rate. It has been reported that the additional money for case management can be or is being used by CSBs to provide other essential services to its consumers. VBPD does not want to see any loss of funds that would affect consumers; however, funds should be used for the purpose they were allocated. The same service should not be compensated at significantly higher rates so that it can fund other services. There should be a transparent budget that reflects where the funding is going.

13. **Low Personal Maintenance Allowance (PMA):** The state’s Home and Community Based (HCB) Waivers require some waiver recipients to contribute to the cost of the covered services. These fees, or “patient pay” (i.e., co-pay) amounts, are determined by DSS by formula. The PMA, however, is not consistent across Waivers (165 percent of SSI, \$1,051.05 in 2008) for all but the AIDS Waiver, which is much higher at 300 percent of SSI (\$1,911 in 2008). In all but the AIDS Waiver, the PMA is insufficient to support successful community living. Individuals with low resources are often unable to pay the required patient pay and meet their personal expenses for shelter, food, and clothing, especially in high income/expense areas such as Northern Virginia. In 2006 the Joint Legislative and Audit Review Commission (JLARC) reported provider feedback that the required patient pay “can be a major barrier to their ability to receive waiver services.” Moreover, JLARC pointed out: “Virginia ranks in the bottom ten states in this allowance.”
14. **Inadequate Services for Persons with Brain Injury:** In its 2006 *Strategic Plan*, DRS noted that the demand for brain injury and spinal cord injury services in Virginia continued to outweigh available resources. According to the 2007 JLARC study, *Access to State-Funded*

Brain Injury Services, although the level of state funding for brain injury services has increased by more than \$2.5 million since FY 2001, some parts of the state had few or inadequate services for brain injury, such as adequate case management, clubhouse or day programs, specialized inpatient/residential facilities for persons with brain injury and severe neurobehavioral disorders, rehabilitation services for cognitive impairments, supportive or transitional housing, and transportation. Most private insurance plans were found to offer limited, if any, coverage for brain injury services. JLARC noted that lack of community services would put persons with brain injury at risk of placement in nursing homes or other long-term care institutions.

- 15. Inadequate Access to Quality Interpreter Services for Persons Who Are Deaf, Hard of Hearing, or DeafBlind:** Concerns were raised at the Board's 2007 public comment events that access to appropriate interpreter services for persons is inadequate statewide. This is true for students with disabilities who require interpreter services in the public school system as well as for children and adults who require these services in other arenas. Lack of access was noted as particularly problematic in colleges and universities, public mental health and substance abuse services, and in public meetings. It is reported by the Virginia Department for the Deaf and Hard of Hearing (DDHH) that it is insufficient just to have access to an interpreter. The interpreter must have the skill level necessary to convey the messages of both the person who is deaf and the person who is hearing. Qualified interpreters are those who have demonstrated skill levels in a variety of situations and, preferably, who have achieved a Virginia Quality Assurance Screening Level II or higher or national certification. A key factor influencing the availability of qualified interpreters has been the growth of Video Relay Services (VRS). VRS uses qualified sign language interpreters to convey information in lieu of traditional text-based telecommunication relay services, such as Virginia Relay. VRS has been able to offer excellent pay and benefits, steady hours, and flexible qualifying credentials to encourage interpreters who have been working in community settings to become full-time VRS interpreters. As VRS and Video Remote interpreting (another video-based service employment interpreter) continues to grow in popularity, the availability of traditional on-site freelance interpreters will continue to diminish. Other factors that contribute to the dearth of qualified interpreters include limited success in recruitment, the limited availability of formal training programs and qualified instructors, and the time needed for a new interpreter to become proficient. Demand and need for these services exceeds supply and the service is costly.
- 16. Services to Children via the Comprehensive Services Act (CSA):** The intent of the Comprehensive Services Act (CSA) has not lived up to its promise 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." The needs of many children continue to be unmet as the result of various factors: lack of available services in some communities, insufficient coordination of services between agencies, and the fact that parents of some children have had to relinquish custody of those children in order for them to receive services. In response to House Joint Resolution Number 60 in 2006, the Joint Legislative and Audit Review Commission (JLARC) conducted an extensive study, *Evaluation of Children's Residential Services Delivered through the*

Comprehensive Services Act. The final JLARC report released in 2007 made a broad range of recommendations to improve availability of needed community services to children and their families, to improve outcomes, and to strengthen oversight protections. The Board defers to the expertise of JLARC with respect to the issues identified and the recommendations made but believes that it should acknowledge the significant challenges faced by children and families served under this system. For his 2008–2010 budget, Governor Kaine proposed financial incentives for use of community-based services rather than congregate care, higher maintenance payments to foster families, and implementation of a data tool with which to track treatment outcomes.

17. **Inadequate Access to Assistive Technology (AT):** Access to assistive technology (AT) can be a critical factor for an individual with a disability to live successfully in the community, to be gainfully employed, and to live a full, productive life. Federal funding for this area has been static; and certain policies and practices themselves are barriers to AT access. With the changes in the federal Assistive Technology Act in 2004, state AT systems must focus 70 percent of funding on AT recycling. Many Disability Services Boards (DSBs) identify access to assistive technology as a challenge in their assessment of local/jurisdictional needs. These needs include: AT assessments and training, access to devices for those who cannot purchase what they need, repair of devices and equipment owned by individuals, and a lack of public awareness of AT. Many of the services offered by the Virginia Assistive Technology System (VATS)—such as information/referral, training, and technical assistance—either are not reimbursable or generate inadequate reimbursement. In addition, as mentioned earlier, individuals receiving AT under Home and Community Based Waivers receive one-time training in the use of the devices but many require and are unable to obtain ongoing training for more complex ATs.
18. **Need for Individualized Budgeting and Increased Consumer Direction:** Service systems that are progressive promote the concept that self-determination is a right of every citizen and demonstrate this fundamental right by offering options such as consumer-directed services and individualized budgeting to the greatest extent possible. Consumer-directed options are growing in Virginia but are still available inconsistently within the array of services covered by Virginia’s Home and Community Based (HCB) Waivers. Among families and providers, there appears to still be a fairly widespread lack of understanding about the meaning of consumer- or family-directed services, self-determination, and person-centered practices. This lack of understanding often results in guardians of individuals with disabilities not believing that the person for whom they have decision-making authority is capable of making any choices and decisions of their own. To the maximum extent possible, an individual’s decision-making authority and options should be based on each individual’s strengths, support needs, likes, preferences, and relationships. This includes individuals who are not verbal or who may need assistance to communicate. Individuals with disabilities and their families need appropriate information and training to choose and direct their own services and to understand that within consumer direction there is a continuum of options. Individualized budgeting can support and enhance increased consumer direction and is also a goal of the Systems Transformation Grant (STG) currently underway with the Department of Medical Assistance Services as the lead agency. An individualized budget would enable

persons with disabilities to have a flexible pool of funds available to them and for which they would be accountable. Individualized budgets would greatly enhance consumer direction of services, and we look forward to its continued evolution and implementation in Virginia.

19. **Inadequate Availability and Use of Alternatives to Guardianship:** Inadequate knowledge about and use of alternatives to guardianship for persons with disabilities continues to be a challenge. Often court-ordered guardianship is executed and the appointed guardian may or may not know the individual for whom he or she is providing decision-making services. With respect to persons residing in state Training Centers, guardians and authorized representatives may make uninformed decisions or decisions that would be inconsistent with the individual's choice. Court-appointed guardians are often unaware of the availability of services and supports that may be obtainable. Students with disabilities who reach the age of majority may lose their rights because parents may seek a determination of capacity in order to obtain guardianship for their children with disabilities. Some parents and school staff members may lack knowledge of less intrusive alternatives, such as limited guardianship or power of attorney. It is clear that there are still many obstacles to maximizing decision-making for persons with disabilities and that many families and authorized representatives continue to obtain full guardianships as a first rather than a last resort. It is very difficult to reverse a court-ordered guardianship once it has been instituted and less restrictive alternatives should be the norm, not the exception.
20. **Enhance Quality of Life in and Oversight of Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) Licensed Community Living Settings:** There is legitimate concern regarding the need to ensure that people with disabilities living in congregate settings in the community enjoy a high quality of life and are free from abuse and neglect. The 2007 *Study of the MR Services System* found that individuals who chose state Training Center placement for their family member most often cited permanence, safety, and welfare as key reasons for their choice, feeling that state facilities are better regulated. Many challenges exist with respect to ensuring good quality and safety but two that stand out are regulations that are not consistent with the values associated with person-centered practices (PCP) and capacity issues within the DMHMRSAS Office of Licensure.

The Virginia Board for People with Disabilities (VBPD) through its participation in statewide workgroups has expressed concern that the current DMHMRSAS regulations (*Rules and Regulations for the Licensing of Providers of Mental Health, Mental Retardation and Substance Abuse Services*, authorized under *Code of Virginia*, § 37.2-404) combine into one set of regulations, standards, and requirements for licensed programs serving persons with mental health, intellectual disabilities, and substance abuse support needs. Virginia's licensure regulations are tied to a medical model approach to services. This approach is counterproductive to systems transformation and incorporating PCP in a *real* way into the daily policies and practices of residential providers, licensing specialists, and stakeholders. This dynamic can create a focus on quality of care versus quality of life inhibiting the latter for persons with intellectual and developmental disabilities. In querying other states, VBPD found that many were surprised that Virginia's regulations were combined for populations

that have such varying needs with respect to services and oversight. Regulations that promote health and safety and quality of life do not have to be mutually exclusive but do need to acknowledge the challenges while fully integrating the values inherent in a person-centered system in policy.

Quality of life indicators must of course be accompanied by adequate monitoring and oversight. The number of licensure staff members has not kept pace with the vast, increasing number of community providers that require monitoring. In the past two years, separate reports have indicated that the current system of state licensure and compliance enforcement has significant inadequacies and needs improvement. In 2006, the DMHMRSAS Office of the Inspector General released a study, *Review of Community Residential Services for Adults with Mental Retardation, Report #126-05*; and the Joint Legislative and Audit Review Commission (JLARC) released its evaluation study of children's residential services funded by the Comprehensive Services Act (CSA). Although these studies differed in the scope of services examined, both pointed out that licensure office staffing in state agencies was inadequate to provide sufficient oversight of the quality of community services; and they recommended identification of and funding for appropriate levels of staff. Both, to varying degrees, recommended that licensure standards be strengthened to include assessment of consumer quality of life and person-centered planning and to strengthen current standards, such as quality of care and staffing levels/qualifications, to better ensure health and safety. The Governor's proposed budget for 2008 included an additional 4 licensure/investigation positions for DMHMRSAS.

H. Board Recommendations for Community Living Supports

In putting forth the following recommendations, which certainly do not represent all changes and improvements required for the Commonwealth's disability service system, the Virginia Board for People with Disabilities (VBPD) would like to begin with the following quote from *The Status of Institutional Closure Efforts* (2005):

Clearly, cost, service quality, and lack of available successful community alternatives are not the reasons . . . institutions remain open. Instead, institutions for persons with ID/DD remain open because some states lack the political will to close or downsize them. Most states provide community supports to most or all of their citizens with ID/DD. Most states have made policy decisions that acknowledge the substantially better quality of life and quality of care in community settings, and which support the right articulated in the New Freedom Initiative for individuals to be free of unnecessarily restrictive living arrangements. The hope is that the others will soon provide similar opportunities to their citizens with disabilities.

1. **Eliminate the Current Dual System of Services:** VBPD continues to recommend that the current institution-based service model be replaced with a defined core set of community-based supports and services that are available on an equitable basis statewide. The Commonwealth should alter its commitment of financial resources to focus on immediate

development of new community-living opportunities as an alternative to institutionalization. Every dollar spent on a Training Center is money not available for community services. The identification of core services in communities statewide should be regarded as a minimum step and should not preclude the development of flexible, new services or the creative utilization of natural supports for which funding may be needed. To address the fear of losing state jobs as a result of state facility downsizing, VBPD recommends that the Commonwealth develop and support jobs in the community for workers who would be affected by downsizing. Virginia should use the model of other states that have provided for comparable wages for direct care professionals and paraprofessionals who support people with intellectual and/or developmental disabilities as they move from institutional to community-living arrangements.

2. **Develop an Inclusive Service System not Based on Disability Diagnosis:** VBPD recommends that the Commonwealth develop and fund a system of services that provides for equitable access to lifelong services, is not dependent solely on Home and Community Based Waivers for funding support, and supports persons with disabilities regardless of specific diagnosis or eligibility for Home and Community Based Waivers. In particular, the statutory focus of the Department of Mental Health, Mental Retardation and Substance Abuse (DMHMRSAS) system on one developmental disability—intellectual disability/mental retardation—has meant that policy, planning, services, and supports for other populations, including but not limited to autism and brain injury, have lagged. VBPD was pleased to participate in the work undertaken by the Joint Commission on Health Care to recommend a “home for Autism” but believes that these efforts should be expanded beyond Autism and that planning and funding services by disability category will result in continued fragmentation of the service system and competition by disability “category” for funding and other resources.
3. **Revise Current Home and Community Based (HCB) Waivers:** VBPD recommends that the Commonwealth consider consolidating Home and Community Based Waivers rather than developing individual waivers for specific populations that continue to promote the disability “silos” discussed above. All Home and Community Based Waivers should be driven by person-centered practices and provide a menu of services from which the individual can choose. In instances in which ongoing training is needed for an individual to access services (such as training in the use of assistive technology), such training should be covered under the HCB Waiver. Consolidation should only be considered if meaningful choice is provided for all Medicaid State Plan or waiver services that would be provided under a consolidated waiver or waivers. VBPD also recommends that existing Home and Community Based Waivers be redesigned to include all supports and services that can be provided through ICF-MR funding, and in particular, services for persons with complex medical needs. This is feasible; it has been done in other states; and it would eliminate the contention and misperception that certain services can only be obtained in an institutional setting.
4. **Improve Access to Home and Community Based (HCB) Waivers:** VBPD supports the recommendations of DMHMRSAS, the Arc of Virginia, and others to make a significant

increase of funding to develop community services, eliminate the HCB Waiver Waiting List and in the interim, and bring the waiting period to reasonable timeframes and predictable levels. VBPD also recommends that access to the MR Waiver be provided for persons in non-state-operated intermediate care facilities for persons with mental retardation (ICFs-MR) and in nursing homes in the same manner as they are available to persons residing in Training Centers. DD Waiver slots are already available to this population. VBPD recognizes the position of advocacy groups that fear that placing persons who reside in institutions on the MR Waiver waiting list will simply lengthen that list. VBPD believes, however, that the true need for waiver slots should be documented and that persons with intellectual disabilities residing in all institutions should have the opportunity to move out of those settings if they so choose. At present, they have little hope of moving to the community because their health, welfare, and safety are presumably being met in the institutional setting. The Money Follows the Person initiative is a positive step in this direction, and it will be important to study the outcomes of this demonstration initiative.

5. **Study Administration of Home and Community Based (HCB) Waiver Waiting Lists:** In 2006, VBPD recommended statewide administration of the Mental Retardation (MR) Waiver Waiting List (see Areas of Concern). In response to opposition from and concern expressed by the intellectual disabilities advocacy community, including the Virginia Association of Community Services Boards and the Arc of Virginia, VBPD recommends that the Joint Legislative and Audit Committee (JLARC) consider conducting a study of waiting list administration under the MR and Developmental Disabilities (DD) Waivers. As an independent legislative body with extensive and well-regarded research credentials, JLARC can conduct an objective independent examination and provide recommendations regarding the strengths and weaknesses of local waiting list administration, statewide waiting list administration, waiting list criteria for both waivers, and any other matters affecting planning and provisions of services to persons on HCB Waiver Waiting Lists.
6. **Increase Provider Rates and Establish Improved Rate Structure:** VBPD recommends that Virginia follow the lead of other states that have implemented initiatives for significant improvement of wages and provide or facilitate health-care coverage and other benefits to direct care workers serving persons with disabilities. VBPD also recommends that the Commonwealth expand incentives for providers who serve individuals in community-living settings, including group homes, but recommend enhanced incentives for the development of supervised apartments, supported living, and other noncongregate living arrangements.

VBPD commends the elimination of the rate disparity between supported employment services funded by the Department of Rehabilitative Services versus those funded under the MR or DD Waivers and recommends the elimination of all such rate disparities. The Board further recommends annual cost-of-living adjustments, regional differentials where needed, and establishment of an intensity-based rate structure that will give incentives to community-based providers to serve persons with more complex and challenging needs.

7. **Increase Personal Maintenance Allowance:** VBPD recommends that Virginia increase the personal maintenance allowance (PMA) for people who receive Home and Community Based Waiver services so that citizens can keep up to 300 percent of Supplemental Security Income (SSI), currently \$1,911 based on the 2008 \$637 monthly SSI maximum payment.
8. **Ensure Provider Choice in All Home and Community Based (HCB) Waiver and Medicaid State Plan Services:** VBPD recommends that the Commonwealth provide individuals with disabilities with a choice in all services and providers of services funded through HCB or Virginia's Medicaid State Plan. To facilitate choice and clear understanding of options by persons with disabilities, DMAS should develop standardized statewide forms for service plans developed under the various HCB Waivers.
9. **Address Gaps in Services to Persons with Brain Injury:** VBPD defers to the recommendations in the September 2007 Joint Legislative and Audit Review Committee (JLARC) report on Access to Brain Injury Services in the Commonwealth. We also agree with the Department of Rehabilitative Services that continued development of a network of "core services" for persons with brain injury (i.e., Regional Brain Injury Resource Coordinators, Specialized Brain Injury Case Managers, and Vocational Clubhouse/Day Programs) is critical to addressing needs in unserved and underserved areas of the Commonwealth. The "core services" are designed to support individuals with brain injury in the community, to prevent placement in institutional settings, and to support the community reentry of people following institutional placement. VBPD recommends exploring the appropriate mechanisms to provide funding for residential neurobehavioral services for people at risk of institutional placement caused by challenging behaviors, since there are no funds currently available for these critically needed specialized services. A Brain Injury Waiver has been under consideration for a number of years but has not been approved for funding.
10. **Maximize Availability of and Resources for Centers for Independent Living:** Consistent with the 2008–2010 State Plan for Independent Living, VBPD recommends expansion of Centers for Independent Living (CILs) to currently unserved geographic areas of the state. VBPD also recommends that current funding levels of Virginia's CILs be reviewed in light of the recommended national average for CIL funding. VBPD recognizes that the current data collection system is federally mandated and standardized; however, CILs may want to look at supplementing these required data to focus more on outcome versus output data, and VBPD recommends conducting additional analyses of these data for better support of funding requests. This should include an analysis of the number of individuals unable to be served because of a lack of resources and the specific needs that could not be met. Identification of gaps in services within and among CILs could help focus resources on those CILs most in need.
11. **Ensure Quality of Life, Health, and Safety in DMHMRSAS-Licensed Community Living Settings:** To alleviate individual and family fears of transition to community-based settings, and particularly congregate settings, the Virginia Board for People with Disabilities

(VBPD) recommends consideration of a number of steps to ensure quality of life, maximum self-determination, and safety. Some of these recommendations were also included in the *2006 Biennial Assessment*.

- A. VBPD recommends that the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMSRAS) consider restructuring its licensure regulations affecting persons with intellectual disabilities and that it review current regulations in light of more-progressive regulations in other states, including but not limited to the Commonwealth of Massachusetts. As noted earlier, Virginia's licensure regulations (*Rules and Regulations for the Licensing of Providers of Mental Health, Mental Retardation and Substance Abuse Services*) are tied to a medical model approach to services that may well be appropriate for the population of individuals with mental illness or substance abuse challenges but has significant weaknesses with respect to appropriately serving persons with intellectual and developmental disabilities. Massachusetts has developed licensure regulations specific to the population of individuals with intellectual disabilities that include a licensure and certification process. The licensure process gives the provider legal authorization to provide services or supports, and is based on the presence of essential safeguards in areas relating to health, safety, and rights. The certification process is one by which outcomes in people's lives, in addition to health and safety, are reviewed. These include relationships, community connections, and individual control and growth accomplishments. These outcomes are equally as important, but can occur over time and are part of a provider's ongoing service enhancement process. Massachusetts has been refining and improving its licensure and certification process since 1994 and it is a national model.
- B. In the interim, with the knowledge that regulatory restructuring would be a lengthy and complex process, VBPD recommends that licensure requirements be revised to ensure that oversight includes quality of life indicators. Requirements should mandate that congregate-living providers have a Quality Assurance (QA) plan specific to each congregate home site and that staff training on the QA plan is documented. DMHMRSAS licensure regulations should reflect a requirement that persons living in licensed congregate settings have person centered plans and supports that meet their unique needs and preferences, not just with respect to the individual's life in that residence, but with respect to his or her broader community-living goals and options such as employment and greater independence, if desired by the individual.
- C. VBPD continues to recommend that the Commonwealth consider establishing "tiered" licensure, and appropriate differential funding, for congregate residences in the community that specialize in serving specific populations, such as those with intellectual disabilities and co-occurring mental illness. Such providers would have direct care staff members who, by verifiable documentation, have the particular skills and knowledge needed to serve the individual best. Each tier or level of residential service could be based on the level of needs of the individuals served, the intensity of supports needed, and "best practices." This concept was also recommended in the strategic plan of the

DMHMRSAS Intellectual Disabilities Special Populations Workgroup, which is comprised of a wide variety of stakeholders statewide.

- D. VBPD recommends that DMHMRSAS continue to work with individuals with disabilities, their families, and community providers to explore creative options for creating local network, Microboards, and “circles of supports” for vulnerable individuals. The creative support options involve a group of people, usually volunteers, who meet together on a regular basis to help somebody accomplish his or her personal goals in life, acting as a community around the individual who needs assistance. Microboards (which are legally incorporated) and circles of support assist individuals to overcome obstacles and increase the options that are open to them and to ensure on an ongoing basis that the work is consistent with the individuals’ personal goals and choices. A recent grant funded by VBPD that focused on the development of Microboards for persons residing in training centers and in the community resulted in the identification of obstacles in both policies and practice that serve as barriers to increased utilization of these creative support options.

12. **Improve Access to Quality Interpreter Services:** In consultation with the Virginia Department for the Deaf and Hard of Hearing, VBPD recommends a comprehensive study of sign language interpreters in Virginia, including but not limited to training needs (both currently available and needed to satisfy the demand), recruitment (both of qualified interpreters from other areas of the country and new interpreters), discovery of successful models in other states, and credentialing. The study should be conducted by a qualified researcher and include representatives from the Deaf Community, the Interpreting Community, and Interpreter Trainers. The study should collect and compare data on interpreters in Virginia with those in other states and provide recommendations relating to technology, training, and incentives.

13. **Increase the Availability of Consumer-Directed (CD) Services and Implement Individualized Budgeting:** VBPD recommends that to the maximum extent possible, consumer-directed services and individualized budgeting be an option in all Home and Community Based (HCB) Waivers. Individualized budgeting paired with CD services promotes flexibility, control, and choice over support needs and services. It can also assist with filling some of the current service system provider capacity gaps. Of note is that individualized budgeting is a goal of the Systems Transformation Grant (STG) currently underway with the Department of Medical Assistance Services as the lead agency. At present STG staff members are conducting a review of policies/procedures in states that currently include individualized budgets as an option in order to identify changes and enhancements needed in Virginia’s policies and procedures to support the use of individual budgets. Following this review the STG team will complete a plan to address inconsistencies and needed changes between all existing state policies and procedures, including dates by which all needed changes will be made and the agency responsible for making them, as well as other logistical and training needs. A report will be developed on how to calculate

individual budgets in Virginia. All of this must be approved by the federal Center for Medicare and Medicaid Services (CMS).

- 14. Support Alternatives to Guardianship:** VBPD recommends that the Commonwealth review its current substitute decision-making alternatives and explore processes by which the state can build capacity to support decision-making through alternative means. A number of states have alternative decision-making models that are more responsive to individuals with disabilities and that allow for a higher degree of self-determination for persons with developmental disabilities for whom decision-making support may be needed. The barriers in law, regulation, and policy to increased self-determination for persons with developmental disabilities should be addressed. User-friendly information on options and alternatives should be readily available to families and professionals.

Community Living Supports Sources Referenced in This Chapter

Web Sites:

Assistive Technology Loan Fund Authority (NewWell Fund): www.atlfa.org

Code of Virginia and Virginia Administrative Code:

www.virginia.gov/cmsportal2/government_4096/codes_and_laws.html

Commonwealth Neurotrauma Initiative: www.vacni.org

Joint Legislative Audit and Review Commission (JLARC): <http://jlarc.state.va.us>

Office of the Inspector General (OIG) for Mental Health, Mental Retardation and Substance Abuse Services: www.oig.virginia.gov

Older Americans Act, Amendments of 2006 (Public Law 109-365):
www.aoa.gov/OAA2006/Main_Site.

SeniorNavigator: www.seniornavigator.org

Statewide Independent Living Council: www.vasilc.org

Virginia Assistive Technology System: www.vats.org

Virginia Association of Community Rehabilitation Programs: www.vaaccses.org

Virginia Comprehensive Services Act: www.csa.virginia.gov

Virginia Department for the Aging: www.vda.virginia.gov

Public Guardianship and Conservator Program, www.vda.virginia.gov/guardianship.asp

Virginia Department for the Blind and Vision Impaired: www.vdbvi.org

Virginia Department for the Deaf and Hard-of-Hearing: www.vddhh.org

Virginia Department of Health: www.vdh.virginia.gov

Virginia Department of Medical Assistance Services: www.dmas.virginia.gov

Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS): www.dmhmrzas.virginia.gov

Virginia Department of Rehabilitative Services: www.drs.virginia.gov
DRS Brain Injury and Spinal Cord Injury Services: www.vadrs.org/cbs/biscis.htm
DRS Community Rehabilitation Case Management: www.vadrs.org/cbs/lterm.htm
DRS Disability Services Council: <http://www.vadrs.org/cbs/dsc>

Virginia Office of the Inspector General for Mental Health, Mental Retardation and Substance Abuse Services: www.oig.virginia.gov.

Virginia Office of Interdepartmental Regulation: www.dss.virginia.gov/division/Interreg

Virginia Rehabilitation Center for the Blind and Vision Impaired: www.vrcbvi.org

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