

VI. Community Supports

A. Introduction

The programs and services in this chapter, broadly referred to as “community supports,” enable individuals with disabilities and their families to determine for themselves where and how they will live and to be fully integrated into all facets of community life. Here, in Virginia, and nationally, expansion of community supports enables ever increasing numbers of individuals with disabilities who have varied levels of support needs to have homes in communities with or near their families rather than reside in institutions. This chapter will focus on publicly funded or operated programs across the Commonwealth that support and encourage self-determination and community integration for these individuals and their families.

Numerous state agencies fund, license, provide, or contract for services and supports that promote community inclusion and integration. Their sources of funds and the regulations governing their application impact eligibility for, access to, and availability of those services and supports. As a result, disability services are often designed to address the specific needs of one or more populations for which an agency or organization is funded, resulting in disability- or age-specific services. The number and diversity of public and private nonprofit and for-profit service providers across the state adds to this complexity, producing multiple points of entry and access, each with its own eligibility criteria.

A number of significant positive developments to improve comprehensive, integrated planning and service delivery for persons with developmental disabilities have occurred since the 2008 edition of this assessment, including the federally funded **Money Follows the Person (MFP) demonstration project** and the **Systems Transformation Grant (STG)**. Elements of these two statewide initiatives have facilitated transition of individuals with disabilities from institutional to community residential settings of their choice, supported the creation and expansion of the **No Wrong Door** online portal for services, fostered person-centered practices in regulations and clinical services, and improved quality assurance and monitoring of critical incidents. While the STG initiative is scheduled to conclude in September 2011, funding for MFP has been extended through federal fiscal year (FFY) 2016. Additional information about the impact of MFP appears later in Institutional Services chapter of this assessment.

In state fiscal year (SFY) 2009, a long-standing goal of disability advocates was achieved with the official designation of a lead state agency responsible for planning and coordination of services for individuals with autism spectrum disorders (ASD) and other developmental disabilities. The role of the existing Virginia Department of Mental Health, Mental Retardation and Substance Abuse Service (DMHMRSAS) was expanded, and its name was changed to the **Department of Behavioral Health and Developmental Services (DBHDS)**.

Concurrent with this development and with the needs of individuals with ASD receiving attention in the state and across the nation, the Virginia General Assembly directed the **Joint Legislative Audit and Review Commission (JLARC)** to conduct a study on the availability and delivery of ASD services in the Commonwealth. Published in June 2009, its *Assessment of Services for Virginians with Autism Spectrum Disorders* (House Document 8, <http://jlarc.state.va.us/Reports/Rpt388.pdf>) covered numerous agencies and programs. Due to its new role with respect to developmental disability services, DBHDS was designated to take the lead in developing a response to the report's 31 recommendations.

In November 2010, with input from multiple agencies and stakeholders, DBHDS released an action plan detailing how the department and its partner agencies plan to address the system issues identified by JLARC and improve the system of care for individuals with ASD. Some of the activities listed below are already underway, while others will require additional funding to be implemented:

- Recommending state adoption of a single, standard definition of developmental disabilities,
- Establishing Community Services Boards (CSBs) as the single point of entry for the developmental disabilities service system,
- Developing an online training program and expanding the DBHDS community college certificate program for direct care professionals who serve individuals with ASD or other developmental disabilities,
- Transferring administration of the Medicaid Individual and Family Developmental Disability (DD) Waiver from the Department of Medical Assistance Services (DMAS) to DBHDS,
- Studying the feasibility and potential impacts of combining the Medicaid Intellectual Disability (ID) and DD Waivers into one comprehensive DD Waiver,
- Expanding Department of Rehabilitative Services (DRS) capacity to meet the growing demand for services for individuals with ASD, and
- Providing state recognition of ASD training developed by the Public Safety Workgroup as a minimum standard for public safety personnel and mandating basic ASD awareness training and ongoing in-service training for all public safety personnel.

DBHDS also engaged in a strategic planning process during state fiscal year (SFY) 2010 that involved over 200 individuals from consumer and provider groups who worked in teams to develop action steps that would address the system's most pressing issues. The result, *Creating Opportunities: A Plan for Advancing Community-Focused Services in Virginia* (www.dbhds.virginia.gov/documents/100625CreatingOpportunities.pdf), was adopted in June 2010. It identifies initiatives and major activities to be undertaken through SFY 2014 to ensure a responsive, well-managed service system for behavioral health and developmental disability services. DBHDS has established implementation teams for each strategic initiative and tasked

them with developing detailed action steps, outcomes, and timelines. An update on these planning activities was published in 2011.

Additional changes to the shape and scope of community services for individuals with intellectual disabilities are anticipated in the Commonwealth's response to the February 2011 **U.S. Department of Justice (DOJ)** findings that the state is noncompliant with the "most integrated setting" tenets of the *Americans with Disabilities Act* (42 USC 12101 et seq.) and the 1999 U.S. Supreme Court decision in *Olmstead v. L.C.* (527 US 581). The DOJ investigation, covered in more detail in the Institutional Services chapter of this assessment, originally focused on the Central Virginia Training Center (CVTC) but was expanded in scope. DOJ found Virginia to be noncompliant based on its over-reliance on institutional care, as evidenced by its long Medicaid Home and Community Based Services (HCBS) Waiver waiting lists and its inadequate community infrastructure, including crisis intervention services.

During its 2011 session, the Virginia General Assembly approved several of Governor Bob McDonnell's budget proposals aimed at expanding the capacity of community supports, including an infusion of \$30 million in general funds into a **Behavioral Health and Developmental Services (BHDS) Trust Fund**. This fund will finance a broad array of community-based services including ID Waiver slots, one-time transition costs for community placements, community housing, and other identified community services needed to transition individuals with intellectual disabilities from the state's training centers to community residential settings. Legislation, including budget amendments, affecting Medicaid and Institutional Services are covered in those chapters of this assessment. Amendments restoring or partially restoring cuts proposed for community-based services in SFY 2012 included:

- \$188,279 for the Department of Rehabilitative Services' (DRS) Community (Long-Term) Rehabilitation Program case management services,
- \$194,931 to provide core safety net services such as case management, transitional day programs, and resource coordination for persons with brain injuries,
- \$160,000 for Centers for Independent Living (CILs), and
- \$5,000,000 to provide services for non-mandated youth under the *Comprehensive Services Act* (CSA).

The Virginia **Office of Comprehensive Services (OCS) for At-Risk Youth and Families** has been working closely with the **Department of Social Services (DSS)** to implement a three-year initiative, funded by the Annie E. Casey Foundation, focusing on the values and principles directing agency interactions with families and service providers. While not specifically targeted at children with disabilities, the **Children's Services System Transformation** changes how youth, particularly children in foster care or at risk of foster care placement, and their families get the help that they need to be more successful at home and in school, stay together, and preserve life-long family relationships. The initiative promotes training in child and family-centered best practices that involve family members, strengthen natural family supports, and increase the use of community-based services.

To better serve young people with brain injury who end up in the criminal justice system, the **Department of Rehabilitative Services' (DRS) Brain Injury Services Coordination (BISC) Unit** is implementing **Closing the Gap**, a grant program funded by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services for 2009 through 2013. Funds granted to DRS will enable it to expand and strengthen the state's infrastructure for delivery of brain injury services and be matched by a sub-grant awarded to **Virginia Commonwealth University** to develop a brain injury screening protocol for all youth entering the **Department of Juvenile Justice (DJJ)** system and train DJJ staff in assessment and intervention. The HRSA funds cannot be used to provide direct services and, instead, will support public awareness, outreach, education and training, and interagency collaboration. By the fall of 2010, project staff had identified best practices for assessment and the screening protocol and had begun ongoing training for DJJ personnel in their implementation.

Anticipating rapid growth of the aging population, including those with disabilities, over the next decade, the 2008 General Assembly directed the **Virginia Department for the Aging (VDA)** to develop a four-year planning process for services to serve that population (*Code of Virginia, 2.2-703.1*). After extensive collaboration with and review of information by other agencies, service providers, gerontologists, and stakeholders at the state and local levels, VDA published its first *Four-Year Plan for Aging Services* in 2009 (www.vda.virginia.gov/pdfdocs/FourYearPlanForAgingServices-RD461-2009.pdf). This comprehensive review of services and challenges statewide for the elderly recommends changes need to more effectively meet both current and future needs and better leverage the human resources of older Virginians. Concurrent with this planning process, VDA and DRS have been exploring opportunities to collaborate and share resources to better integrate and coordinate services for individuals who are older or have disabilities, and in 2010, the DRS Commissioner was appointed as Interim-Commissioner for VDA to facilitate their joint efforts.

Since 2003, the federal **Administration on Aging (AOA)** and the **Centers for Medicare and Medicaid (CMS)** have collaborated to help states transform their long-term care service systems to better meet the needs of the growing number of individuals who are elderly or have disabilities using funds provided by AOA's **Aging and Disability Resource Centers (ADRC)** grant program. ADRC grants fund the creation and maintenance of one-stop points of access for long-term care information and services regardless of age or type of disability and encourage states to build effective service capacity and infrastructure that is person-centered and self-directed. More information on the Commonwealth's **No Wrong Door** initiative, a public and private joint effort led by VDA, can be found at www.vda.virginia.gov/nowrongdoor.asp.

In late 2010, VDA, the Partnership for People with Disabilities at Virginia Commonwealth University, the Area Agencies on Aging (AAAs), and the Centers for Independent Living in Virginia's seven No Wrong Door regions began work on a follow-up **ADRC Options Counseling** project. This two-year project, funded by AOA for just over \$513,000, will help persons who are older or have disabilities understand, evaluate, and manage the full range of services and supports available in their communities for long-term care and

decision-making. The CILs have long provided this type of service for their clients, and statewide standards are being developed to reflect equal perspectives from the aging and disability communities.

The **Community Living Program**, another relatively new AOA grant administered by VDA, is similar to the MFP and STG initiatives described earlier. It encourages states to use funding received under the *Older Americans Act* or other non-Medicaid sources for more flexible, consumer-directed services that support older individuals in “aging in place.” This strengthens the state’s ability to assist older individuals, who are at risk of nursing home placement and having to “spend-down” their assets to become eligible for Medicaid, remain in their homes and communities as independently as possible and experience an improvement in their quality of life through self-direction of services. The \$939,730 in federal funds received by VDA for this program will cover 23 percent of service costs with the balance coming from *Older American Act* funds, state general funds, and local funds.

Complementing all these efforts, the 2010 General Assembly directed the Secretary of Health and Human Resources (HHR) to lead an initiative to develop a **Blueprint for Livable Communities and Long-Term Care Services** for Virginians who are elderly or have a disability (*Code of Virginia*, 2.2-213.4). Drawing on existing reports and plans, multiple state agencies as well as other public and private organizations, led by VDA, have been developing a comprehensive statewide plan extending through state fiscal year (SFY) 2025. That plan must address “...(i) community integration and involvement, (ii) availability and accessibility of services and supports, and (iii) integration and participation in the economic mainstream.” The blueprint must be submitted to the Governor and legislative fiscal committees no later than June 30, 2011.

Since 2007, as detailed in the Community Housing chapter of this assessment, the **Statewide Independent Living Council (SILC)** has made a significant financial commitment of its federal funds to improve access to affordable, accessible housing for persons with disabilities, a essential component of all the community integration and self-determination efforts described above. The *Code of Virginia* (51.5-25.1) establishes the SILC as an independent planning and advocacy body charged with developing a three-year *State Plan for Independent Living* (www.vasilc.org/statewideindependentlivingcouncil.htm). Its members are appointed by the Governor to be representative of persons with significant disabilities from across the state, the Centers for Independent Living (CILs), and other recipients and providers of independent living services. The SILC’s goals include promoting individual empowerment and youth advocacy, assisting CILs with service to unserved and underserved populations, and supporting effective policies, programs, and activities that improve community-based services and maximize independence for Virginians with disabilities.

Along with the SILC, Virginia’s **Disability Services Boards (DSBs)** have long provided advice and assistance to the state’s system of community living supports for individuals with disabilities. Initially authorized in 1992 (*Code of Virginia*, 51.5-47), these boards were established to assist localities in identifying and addressing the needs of persons in their

communities with physical and sensory disabilities. Some serve a single jurisdiction, and others are multi-jurisdictional. DSB members include representatives of local government, business and industry, and the community at large. By statute, at least 30 percent of their members must be individuals with physical, visual, or hearing disabilities or members of their families. The scope and scale of DSB activities vary, dependent on their individual mix of public and private resources and local needs. The 2010 General Assembly eliminated DSBs as a mandated local function and, in 2011, eliminated state funding for their administration and management; therefore, their future is uncertain. As of late 2010, there were still 18 DSBs in existence statewide, with four transitioning into a different type of entity with a similar purpose. Ten were no longer active, and the status of eight previously established DSBs was unknown.

A description of all community-based programs and supports available to individuals with developmental and other disabilities is beyond the scope of this, or perhaps any, report. As noted at the beginning of this introduction, this chapter focuses on the services and supports that state agencies operate, administer, license, or pay for using state general funds or other financial resources including matching Medicaid funds. Details concerning services that can be accessed through the Medicaid State Plan and Medicaid Home and Community Based Services (HCBS) Waivers are covered in the Medicaid chapter of this assessment. The other community supports covered by this chapter are organized by the following key programs and services:

- Assistive Technology (AT) and Related Services,
- Brain Injury (BI) and Spinal Cord Injury (SCI) Services,
- Community Rehabilitation Case Management (CRCM) Services,
- *Comprehensive Service Act (CSA)*,
- Independent Living and Related Services,
- (Non-Waiver) Intellectual Disability Services,
- Interpreter Services and Related Programs for the Deaf and Hard of Hearing,
- *Omnibus Budget Reconciliation Act (OBRA) Services*,
- (Non-Waiver) Personal Assistance Services (PAS), and
- Services for the Elderly Population.

The array of community living services available to United States military personnel and veterans who have been injured during their service to the country is not a focus of this report. For the most part, these services are fully federally funded and provided by the U.S. Veterans Administration (VA); although, some rehabilitative services are offered by state disability agencies through Virginia's **Wounded Warrior Program** (<http://wearevirginiaveterans.org>). Veterans who sustain severe permanent injuries, such as traumatic brain or spinal cord injury, and are under the age of 22 at the time they are injured, however, may meet the definition of having a developmental disability and qualify for many of the services covered in this chapter on that basis. The state Department of Veterans Services (www.dvs.virginia.gov) can assist

individuals in accessing information, benefits, and services through the federally operated VA centers located statewide.

B. Eligibility for Community Supports

Assistive Technology (AT) and Related Services: Eligibility for AT, defined by state regulations (22 VAC 30-20-10) as "...any item, piece of equipment, or product system... that is used to increase, maintain or improve the functional capabilities of an individual with a disability," and related services varies by program. AT devices range from "reachers" and other simple mechanical aids to devices as complex as electric wheelchairs that responds to breath controls or adaptive environmental controls that respond to voice commands. AT services refer to "...any service that directly assists an individual with a disability in the selection, acquisition or use" of an AT device and may include:

- Functional evaluation of an individual in his or her natural environment;
- Leasing or providing AT equipment;
- Customizing, maintaining, repairing, or replacing AT;
- Training or technical assistance in using AT for an individual with a disability and, as appropriate, for his or her family, guardian, or authorized representative); or
- Training or technical assistance to professionals, employers, or others who employ, serve or "are substantially involved in the major life functions of individuals with disabilities" in order to achieve an employment outcome.

The **Department of Rehabilitative Services (DRS)** provides AT services for individuals with disabilities of all ages and levels of ability through its **Virginia Assistive Technology System (VATS)**, as authorized by the federal *Assistive Technology Act* of 2004, as amended, and its **Virginia Reuse Network (VRN)**. Applications for VATS assistance are available online (www.vats.org), by phone, or at each of its regional offices. VRN programs (www.vats.org/atrecycling.htm) vary in the devices and services that they provide, with program-specific waivers of liability and other forms that can be completed when an individual comes in to select a needed device.

DRS' **Woodrow Wilson Rehabilitation Center (WWRC)** in Fishersville, Virginia, provides adolescents and adults with disabilities from across the state with a variety of AT services through outpatient clinics and residential programs. Priority is given to current DRS clients for whom AT is urgently needed to obtain or keep a job, and its more intensive residential AT services have more specific eligibility criteria than its outpatient programs. Detailed eligibility information is available on WWRC's website (www.wwrc.virginia.gov/admissions.htm) or by contacting the facility directly.

The **Technology Assistance Program (TAP)** of the **Virginia Department for the Deaf and Hard of Hearing (DDHH)** provides AT services (www.vddhh.virginia.gov/TechIntro.htm)

for individuals who are deaf, hard of hearing, deafblind or otherwise both hearing and vision impaired, or who have speech impairments that prevent them from using a standard telephone. To be eligible, an individual's disability must be verified by a licensed professional, a DDHH outreach specialist, or an appropriate representative of DRS, the Department for the Blind and Vision Impaired (DBVI), or the Virginia School for the Deaf and Blind. Individuals must also provide proof of residency and meet financial guidelines. Income limits are based on the federal poverty level (FPL) and may vary from year to year. The current limit is an income of no more than 250 percent of FPL. There are no age restrictions, but applications for children and youth under age 18 must be cosigned by a parent or legal guardian. Eligible applicants are served first-come, first-served based on available funds. DDHH may give priority to new applicants or to recipients who have not received AT equipment in the previous four years and who do not have functioning equipment, as verified by DDHH or a vendor. Fees for services are determined by a sliding scale based on ability to pay.

The **NewWell Fund** (www.newwellfund.org), administered by the public Assistive Technology Loan Fund Authority (ATLFA), assists Virginia residents with disabilities, as defined for the program's purposes, and their families in securing low-interest loans to purchase AT devices or related services. Assistance is also available for a small business or nonprofit organization if they can demonstrate that the loan will be used to acquire AT for employment or retention of one or more persons with disabilities or will be used to make structural modifications consistent with the *Americans with Disabilities Act* (ADA) that will benefit people with disabilities. Prospective borrowers must demonstrate their creditworthiness and repayment ability, based on credit history, income, and debt, to the satisfaction of the NewWell Fund; however, individuals with either no credit history or poor credit due to disability or medical issues are given special consideration.

Brain Injury (BI) and Spinal Cord Injury (SCI) Services: Services for persons with brain or spinal cord injuries are designed to facilitate community reintegration and personal independence. Outreach, information, and referral services for persons with brain injury are provided by the **Brain Injury Services Coordination (BISC) Unit** located within the Community Based Services Division of the Department of Rehabilitative Services (DRS). Individuals with brain or spinal cord injuries may also apply directly or be referred by DRS counselors for services from the two corresponding programs at DRS' Woodrow Wilson Rehabilitation Center (WWRC) mentioned above.

The **WWRC Brain Injury Services Department** (www.wwrc.virginia.gov/braininjuryservices.htm) serves individuals with either traumatic or non-traumatic acquired brain injury. Those individuals must be "...medically, physically, and psychologically stable with a favorable prognosis for participating in, completing, and benefiting from the services," and their current behavior must be unlikely to jeopardize the health and safety of themselves or others or to jeopardize the rehabilitation program. Applicants with a co-occurring psychiatric diagnosis or a history of substance abuse must be able to demonstrate six consecutive months of stability. As a part of the application and referral process, an individual must typically complete a one-day

feasibility outpatient evaluation at WWRC to clarify his or her current neuro-behavioral functioning and what services are needed.

Individuals eligible for the **WWRC Spinal Cord Injury Services** (www.wwrc.virginia.gov/spinalcordinjury.htm) must be medically stable following spinal cord injury or disease and have the potential to benefit functionally from the comprehensive rehabilitation evaluation and treatment services that it offers. As noted previously, DRS clients pursuing vocational goals are given priority.

The DRS BISC Unit also administers the **Brain Injury Direct Services (BIDS) Fund** that supports rehabilitation enabling individuals to live more independently and progress in their recovery. To be eligible for assistance, individuals must:

- Have a documented acquired brain injury,
- Be at least one year post-injury,
- Reside in an institution or be at risk of institutionalization,
- Have completed acute care hospitalization and medical rehabilitation stages of recovery,
- Have no other public or private source of funds available (such as Medicaid, private insurance, or other DRS assistance),
- Meet DRS financial eligibility or be willing to share in the cost of services, and
- Have a family or other support person willing to participate in the program.

The required written application for BIDS Funds is available online; however, because these funds are limited, individuals are encouraged to contact the BISC Unit (www.drs.virginia.gov/cbs/biscis.htm) prior to submitting an application to verify that funds are available.

Community Rehabilitation Case Management (CRCM) Services: This program operated by the Department of Rehabilitative Services (DRS) matches individuals who have severe physical or sensory disabilities with appropriate community services and supports. As a result of their disability, these individuals must require a special combination of life-long or extended duration services and have substantial limitations in three or more of the following life areas: communication, independent living, mobility, learning, self-care, self-direction, or economic self-sufficiency. Residents of skilled nursing facilities are eligible for CRCM Services, including transition to community assistance, through the *Omnibus Budget Reconciliation Act* (OBRA, see below) Nursing Home Outreach Service. CRCM Services also provides support coordination (case management) for a limited number of individuals under the Medicaid Home and Community Based Services (HCBS) Individual and Family Developmental Disability (DD) Waiver.

CRCM Services applicants must meet disability and financial eligibility requirements based on the service being requested, and because resources are limited, the priorities listed

below exist for accessing CRCM Services support coordination services. At all priority levels, preference is given to public safety officers and military veterans disabled in the line of duty.

- Priority I: Individual is in danger of being placed in a psychiatric facility, nursing home, or other institutionalized setting or is approved for short-term services through the DRS Brain Injury Direct Services (BIDS) Fund.
- Priority II: Individual has no support service system in place and is not receiving service coordination services through any agency or organization.
- Priority III: Individual has an identified need for case management that will improve overall quality of life and access to needed supports and services.
- Priority IV: Individuals who meet program eligibility requirements will be considered in order of application.

Comprehensive Services Act (CSA): This goal of this statute (*Code of Virginia, 2.2-5200 et seq.*) is to "...create a collaborative system of services and funding that is child-centered, family focused, and community based when addressing the strengths and needs of troubled and at-risk youth and their families..." Because it pools eight funding streams across four state agencies for which multiple federal mandates must be met, multiple eligibility criteria for services under the CSA exist. To be eligible, children and youth must be younger than either age 18 or 22, depending on the service, and, in general, would have been eligible for services through one of its eight funding streams.

The CSA targets the following five populations, of which only the first three are mandated for services:

1. Children placed in approved private school education programs for purposes of special education previously funded by the Department of Education through private tuition assistance;
2. Children with disabilities placed by local social services agencies or by the Department of Juvenile Justice in private residential facilities or across jurisdictional lines in private special education day schools, if the individualized education program indicates such school is the appropriate environment in which to receive services while living in foster homes or child-caring facilities;
3. Children for whom foster care services, as defined by the *Code of Virginia* (63.2-905), are being provided to prevent foster care placements and children placed through parental agreements, entrusted to local social service agencies by their parents or guardians, or committed to the agencies by any court of a competent jurisdiction;
4. Children placed by a Juvenile and Domestic Relations District Court in a private or locally operated public facility or nonresidential program or in a community or facility-based treatment program; and
5. Children committed to and placed by the Department of Juvenile Justice into a private home or in a public or private facility in accordance with the *Code of Virginia* (66.14).

The CSA further requires that one or more of the following criteria be met for an individual described above to receive services under the statute (*Code of Virginia*, 2.2-5212[A]):

1. “The child or youth has emotional or behavior problems that:
 - a. “Have persisted over a significant period of time or, though only in evidence for a short period of time, are of such a critical nature that intervention is warranted;
 - b. “Are significantly disabling and are present in several community settings, such as at home, in school or with peers; and
 - c. “Require services or resources that are unavailable or inaccessible, or that are beyond the normal agency services or routine collaborative processes across agencies, or require coordinated interventions by at least two agencies.
2. “The child or youth has emotional or behavior problems, or both, and currently is in, or is at imminent risk of entering, purchased residential care. In addition the child or youth requires services or resources that are beyond normal agency services or routine collaborative processes across agencies, and requires coordinated services by at least two agencies.
3. “The child or youth requires placement for purposes of special education in approved private school educational programs.
4. “The child or youth has been placed in foster care through a parental agreement between a local social services agency or public agency designated by the community policy and management team and his parents or guardian, entrusted to a local social services agency by his parents or guardian, or has been committed to the agency by a court of competent jurisdiction for purposes of placement” as authorized by the *Code of Virginia* (63.2-900).

Localities may choose to serve non-mandated youth with emotional or behavioral problems who meet CSA eligibility criteria; however, there is no legal requirement that local governments provide the matching funds to do so. The **Office of Comprehensive Services (OCS) for At-Risk Youth and Families** (www.csa.virginia.gov) that administers the CSA reports that 93 percent of the children and youth served in state fiscal year (SFY) 2007 and 92 percent of those served in SFY 2010 were categorized as mandated.

Independent Living and Related Services: Training and support in areas such as self-advocacy and assertiveness, stress management, communication, social and relationship skills, home management, personal hygiene and wellness, meal planning and preparation, shopping, and money management make it possible for individuals with significant disabilities to maintain or increase their self-reliance. Although a variety of public and private entities offer these services, they are primarily provided by the state’s **Centers for Independent Living (CILs)** and the **Rehabilitation Teaching/Independent Living (RT/IL) Program** of the Department for the Blind and Vision Impaired (DBVI).

The Commonwealth's CIL program (www.drs.virginia.gov/cbs/cils.htm), authorized under the federal *Rehabilitation Act* of 1932 as amended (PL 93-112) and the *Code of Virginia* (51.5-23-25), funds community-based, cross-disability, non-residential agencies operated by and for individuals with disabilities. Anyone with a significant disability is eligible for services from a CIL in the localities across the state where they exist. The *Rehabilitation Act* defines an individual with a significant disability as someone with a significant physical or mental impairment whose ability to function independently in the family or community or to obtain, maintain, or advance in employment is substantially limited. The statute further specifies that services should be provided when they will improve the individual's ability to function, continue functioning, move toward independent functioning in the family or community, or improve his or her ability to continue in employment.

The DBVI RT/IL program (www.vdbvi.org/RTILS.htm) specifically targets individuals who are blind or have related visual or sensory impairments and provides services enabling those individuals to maximize their economic, social, and personal independence and participation in community life. The program funds services for more than 267,000 Virginians of all ages. Eligibility for RT/IL services requires verification of residence and medical documentation of the nature and scope of the vision impairment. Generally, an individual must have, in the better eye, visual acuity (with correction if needed) that is worse than 20/70 or a visual field that is less than 70 degrees across. Once basic eligibility has been determined, the individual can be referred to the Orientation and Mobility Program, DeafBlind Services, Low Vision Services, or other DBVI programs based on needs identified through a functional assessment by a DBVI Rehabilitation Teacher. Financial participation requirements, based on a formula intended to identify individuals with the greatest economic need, exist for the purchase of some equipment. Financially eligible individuals receive tangible goods and services at no cost. Those declared financially ineligible may be required to pay some or all of the costs for certain goods and services. Financial eligibility criteria are updated annually.

Independent living services may also be obtained from **Employment Service Organizations (ESOs)** that are authorized to provide these services by the Department of Rehabilitative Services (DRS). ESO independent living services approved by DRS may or may not be related to vocational rehabilitation. Additional information on ESOs and the services that they provide can be found in the Employment chapter of this assessment.

(Non-Waiver) Intellectual Disability Services: The **Virginia Department of Behavioral Health and Developmental Services (DBHDS)** is responsible for planning, monitoring, and overseeing publicly funded services for individuals with intellectual disabilities. To do so, it contracts with 37 independent, local **Community Services Boards** and three **Behavioral Health Authorities** (collectively referred to as **CSBs**) that are designated by the *Code of Virginia* (37.2-500 and 37.2-601) as the single point of entry into the state's mental health, intellectual disability, and substance abuse services system.

In addition to a diagnosis of intellectual disability, eligibility requirements for specific services vary by their nature and funding availability. CSBs determine whether individuals are

eligible, coordinate service delivery, and often provide the services themselves. At the time of this assessment, individuals with developmental disabilities who do not have a concurrent intellectual disability are not eligible for CSB services unless a locality has chosen to offer them and has the resources to do so. The designation of DBHDS as the lead state agency for individuals with developmental disabilities, including autism spectrum disorders (ASDs), has so far not been accompanied by additional funding for it or the CSBs to provide services for this expanded population.

Interpreter Services and Related Programs for the Deaf and Hard of Hearing: The Interpreter Services Program (www.vddhh.virginia.gov/IpAbout.htm), administered by the **Department for the Deaf and Hard of Hearing (DDHH)**, provides critical communications services for Virginians of any age who are the deaf, hard of hearing, deafblind, or have speech impairments and use sign language. The *Code of Virginia* (51.5-113) authorizes DDHH to coordinate the services of sign language interpreters for all state agencies. This includes colleges and universities; however, DDHH contracts do not cover interpreters in higher education.

Various state laws mandate court appointment of interpreters for individuals who are deaf. In each of these instances, the cost for interpreters is borne by the state; however, the person who is deaf may waive his or her right to a court-appointed interpreter and provide one at his or her personal expense. Individuals who are deaf are entitled to a court-appointed interpreter by statute when they are:

- Alleged to have a mental illness or intellectual disability and facing commitment or certification (37.2-802 and 37.2-815,;
- A party or a witness to a civil proceeding and request such assistance (8.01-384.1),
- Involved in a criminal case as either the victim of or witness to a crime (19.2-164.1), or
- Accused under trial in a criminal case (19.2-164.1).

DDHH also administers the federally mandated **Virginia Relay** system (www.varelay.org) for individuals who are deaf or hard of hearing and those who want to communicate with them. Virginia Relay provides traditional voice-carry-over, hearing-carry-over, and voice-to-voice services for individuals with hearing loss or speech impediments as well as new CapTel technology that transmits both voice and text. Additional information about the different types of service as well as an application to obtain one of the limited number of CapTel devices available from DDHH are available on the Virginia Relay website.

Omnibus Budget Reconciliation Act (OBRA) Services: This federal statute (PL 100-203), passed in 1987, requires states to evaluate individuals with intellectual disabilities or related conditions being considered for admission to a Medicaid-funded nursing facility to determine whether they require that level of services. Then, for individuals admitted to a facility, a determination must be made whether they continue to need nursing facility care whenever a resident review indicates a significant change in condition or at least annually. As a part of these evaluations, it must also be determined what specialized services are needed to maximize self-

determination and independence for these individuals and whether they can benefit from receipt of those services. When a resident is determined to no longer need nursing facility level of care or chooses community-based services, the state must begin the discharge process, including resident preparation and arrangements for or provision of those specialized services when they are not provided by the nursing facility or covered under the Medicaid State Plan.

In Virginia OBRA requirements (www.dbhds.virginia.gov/omh-obra.htm) are collaboratively fulfilled by the **Department of Medical Assistance Services (DMAS)**, **Department of Rehabilitative Services (DRS)**, and **Department of Behavioral Health and Developmental Services (DBHDS)**. DBHDS is responsible for the pre-admission screening and subsequent evaluations, determination of specialized service needs, and providing or arranging for delivery of those services. Typically, individuals eligible for services under OBRA have a significant disability arising from cerebral palsy, epilepsy, autism, brain or spinal cord injury, muscular dystrophy, multiple sclerosis, spina bifida, stroke, or other conditions of neurological origin. Persons with developmental, including intellectual, disabilities eligible for services under OBRA must have a significant disability that was evident before age 22, and a determination must be made that the individual needs and can benefit from specialized services.

(Non-Waiver) Personal Assistance Services (PAS): Individuals with physical disabilities, such as spinal cord injuries, cerebral palsy, and muscular dystrophy, who require assistance from another person to perform nonmedical activities of daily living and are not eligible for these services under vocational rehabilitation, a Medicaid Home and Community Based Services (HCBS) Waiver, or any other program may be eligible for personal assistance services (PAS) through one of two programs by the **Department of Rehabilitative Services (DRS)**. To qualify for consumer-directed, **State-Funded PAS** (www.drs.virginia.gov/cbs/pas.htm) or **PAS for Individuals with Brain Injury (PAS/BI)**, an individual must submit an application for services, after which an assessment is made to determine service needs and ascertain whether comparable services can be obtained from any other source. If funding becomes available to serve additional participants, assessments are conducted for each applicant, and selection for services is based on severity of need.

Additional information on consumer direction appears in the Medicaid chapter of this assessment. PAS/BI is only available for a limited number of individuals (four to eight) who wish to designate a representative to assist them in managing their PAS services. Vocational rehabilitation services by DRS and the Department for the Blind and Vision Impaired (DBVI), which may include PAS, are covered in the Employment chapter.

Services for the Elderly Population: While many state agencies provide services across the lifespan, the **Virginia Department for the Aging (VDA)** is responsible for oversight of all state programs funded through the federal *Older Americans Act*, as amended in 2006 (PL 109-365), and certain related appropriations by the Virginia General Assembly. These programs are coordinated and provided by VDA in contractual partnership with local **Area Agencies on Aging (AAAs)** that tailor their services to the needs of local residents (www.vda.virginia.gov/aalist.asp).

AAAs offer information, referrals, and technical assistance to anyone in their area ages 60 and over or ages 18 through 59 with disabilities, their family members, and caregivers. For other AAA services, individuals must be age 60 or over, except for the **Title V Senior Community Service Employment Program** that serves Virginians ages 55 and over. Priority for services is given to older individuals who are in the greatest economic and social need and to those who are at risk for institutional placement. Preference is also given to older individuals who are part of a low-income minority population, have limited English proficiency, or live in rural areas. Adult caregivers of older individuals or individuals under age 50 with early onset dementia are eligible for services under the **National Family Caregiver Support Program (NFCSP)**. Family members who are aged 55 and over who are caring for children ages 18 and under or adults ages 18 through 59 with a severe disability may also receive NFCSP services. Some AAA in-home and community services are provided on a sliding fee scale based on an individual's ability to pay.

As noted in the introduction to this chapter, the VDA's **Community Living Program** (www.vda.virginia.gov/communityliving.asp) that helps Virginians age in place is a relatively new initiative being piloted in ten AAAs. The AAAs involved in the program identify and enroll participants, offer consumer-directed services, and participate in program evaluation activities. To be eligible for the program, individuals must meet all of the following criteria:

- Be 65 years of age or older,
- Have a family caregiver who demonstrates difficulty meeting the individual's needs,
- Need assistance because of either a cognitive impairment or an impairment in at least two activities of daily living (ADLs),
- Have income at or below 300% of Social Security Income (\$2,022 a month at the time of this assessment), and
- Likely for denial of Medicaid eligibility due to excess liquid resources such as savings, bonds, or certificates of deposit.

The **Public Guardianship Program** (www.vda.virginia.gov/vapublicguardpgm.asp), also managed by VDA, funds local human service agencies that provide those services for persons aged 18 and over, not just the elderly, who have been determined to be unable to care for themselves or make decisions about their care (are "incapacitated"), are indigent, and do not have a suitable person willing or able to serve as their decision-maker. Due to funding limitations, this program is not available in all areas of the state and cannot fund services for all individuals needing them.

In addition to the above programs by the VDA and AAAs, the **Department for the Blind and Vision Impaired (DBVI)** administers the **Older Blind Grant Program** (www.vdbvi.org/RTILS.htm) for Virginia residents ages 55 and over who have documented blindness or a severe visual impairment that significantly interferes with normal life activities. DBVI staff provide free assessments, one-on-one training, and instructional services for all individuals; however,

financial eligibility requirements must be met for coverage of costs associated with such services as the provision of adaptive equipment for individuals who are blind or vision impaired.

The **Program of All-Inclusive Care for the Elderly (PACE)**, a Medicaid State Plan optional service funded and administered by the **Department of Medical Assistance Services (DMAS)** is another program specifically targeted at older Virginians (http://dmasva.dmas.virginia.gov/Content_pgs/ltc-pace.aspx). PACE provides the entire continuum of medical care and supportive services needed by Virginians age 55 and over to age in place and remain in community-based settings, avoiding more restrictive and costly institutional placement. To be eligible for PACE, state regulations (12 VAC 30-120-63) specify that an individual must:

- Be 55 years or older;
- Meet level of care criteria for a nursing home or, if an individual with an intellectual disability, the level of care of an intermediate care facility for persons with mental retardation (ICF-MR);
- Reside in the service area of a PACE organization; and
- Have his or her health, safety, and welfare “assured in the community.”

Individuals who are eligible for Medicaid or dually eligible for both Medicaid and Medicare are also eligible to enroll in PACE. Generally, income must be equal to or less than 300 percent of the current Supplemental Security Income (SSI) payment standard for one person, and their financial resources must be equal to or less than the resource allowance established in the current Medicaid State Plan. Other eligibility requirements may be specified under the PACE program agreement with providers. To determine eligibility, a preadmission screening team under contract with DMAS conducts a formal evaluation of an individual using the Uniform Assessment Instrument (UAI), a standardized questionnaire (*Code of Virginia, 32.1-330*). PACE also accepts individuals who pay privately and meet other eligible criteria.

C. Access to and Delivery of Community Supports

Assistive Technology (AT) and Related Services: These services may be provided on an outpatient basis in an office, in the individual’s home, or within a residential program. Sources of AT services and equipment include local school divisions, vocational rehabilitation agencies, private vendors on a fee-for-service basis, and other local programs. Each has its own process for access and delivery, and an individual with a disability may have access to AT through multiple programs at different times based on different needs. In addition to their basic procedures, each source of AT has its own appeals process, such as mediation and informal or formal hearings, to deal with situation in which individuals with disabilities, their family members, and service providers disagree on the need for or type of AT.

The **Department of Rehabilitative Services’ (DRS) Virginia Assistive Technology System (VATS)** provides services through its central office in Richmond and three regional sites: Southwest VATS at Virginia Tech in Blacksburg, Southeast VATS at Old Dominion

University in Norfolk, and Northern VATS at George Mason University in Fairfax. Information, referrals, and other assistance are also available by phone (800-552-5019, toll-free) or online (www.vats.org/contactus.htm). During federal fiscal year (FFY) 2010, VATS made 51 loans of AT equipment, conducted 128 demonstrations and 2,098 trainings, and provided information or other assistance to 2,096 contacts.

In addition to VATS regional university sites, DRS' **Woodrow Wilson Rehabilitation Center (WWRC)** provides comprehensive technology assessments and customized technology services through a variety of programs. Policies and access procedures vary among the programs, dependent on the needs of the individuals that they serve. WWRC program teams may include rehabilitation and computer systems engineers, physical and occupational therapists, speech/language pathologists, and social workers, as needed. Additional information is available online, from a widely distributed interactive CD-ROM, or by contacting WWRC directly.

The table below shows the substantial increase in the number of individuals receiving AT services through WWRC programs from state fiscal year (SFY) 2007 to SFY 2010. While most clients still receive services through outpatient programs, recent growth in residential services (64 percent) has exceeded that for outpatient services (53 percent).

**NUMBER OF PERSONS RECEIVING ASSISTIVE TECHNOLOGY SERVICES
THROUGH THE WOODROW WILSON REHABILITATION CENTER (WWRC)**

Type of Program	SFY 2007	SFY 2010	Change	Percent
Residential	58	95	+37	+64%
Outpatient	258	394	+136	+53%
Total	316	489	+173	+55%

Source: Department of Rehabilitative Services (DRS).

Since October 2010, new grant funds have enabled VATS, WWRC, and the Foundation for Rehabilitation Equipment and Endowment (F.R.E.E.) to collaboratively build and administer a statewide **Virginia Reuse Network (VRN)** to help meet the rehabilitation equipment needs of Virginians with disabilities, particularly those who lack resources to purchase this equipment on their own. Local public and private partners supply VRN with volunteers and generate donations of gently used rehabilitation equipment and funds. This equipment is sanitized, repaired or refurbished, and redistributed through regional recycling centers (www.vats.org/atrecycling.htm).

During FFY 2010, VRN provided recycled AT to 418 individuals, bringing the total number of individuals served by statewide reuse programs since FFY 2006 to 8,025. These individuals have received 9,537 devices valued at \$3,473,646. Over the next three years, using funding from the Commonwealth Neurotrauma Initiative (CNI), the federal *American Recover and Reinvestment Act* (ARRA) and *Assistive Technology Act*, VRN plans to build further capacity to more effectively serve persons with spinal cord injuries, traumatic brain injuries, veterans with disabilities, and DRS vocational rehabilitation participants.

Individuals seeking information or services from the **Virginia Department for the Deaf and Hard of Hearing's (DDHH) Technology Assistance Program (TAP)** may contact either DDHH or one of its 15 local **Loan-To-Own (L2O)** providers. During the two years prior to this assessment, DDHH completed transition from its previous system of TAPLoan centers across the Commonwealth to its new L2O contractual outreach program. While the four remaining TAPLoan centers no longer have a contractual agreement with DDHH and new equipment is no longer available through those sites, access to AT has not decreased as a result of this transition. Through TAP L2O, a qualified individual has the opportunity to test various technologies and devices designed to enhance independence and quality of life for persons with hearing loss. At the end of a 30-day loan period, if a device meets his or her communications needs, ownership is permanently transferred. During the loan period, if the device is not meeting his or needs, the individual may exchange it for a different device to test in the home or workplace for an additional 30 days. All devices carry a one-year warranty, and qualified TAP participants can apply for new equipment every four years.

In state fiscal year (SFY) 2007, TAP provided equipment to 523 eligible individuals, a decrease of 13.3 percent from the 603 served in SFY 2005. Full implementation of the TAP L2O program improved access to AT through online submission of applications, decentralization of equipment inventory, and elimination of waiting times for receipt of equipment. As a result, the number receiving equipment increased by 110 percent to 1,099 in SFY 2010. An additional 1,834 individuals received technical assistance that year, and as of July 1, 2011 TAP has been entirely funded through state special funds, not general funds.

DDHH also provides generalized outreach services that include training, technical assistance, information and referral, and library services. During SFY 2010, it had a total of 37,779 outreach program contacts, down significantly from 71,141 in SFY 2007. Two main factors contributed to this decrease. DDHH funding for outreach contracts was reduced by 30 percent, and its library was closed due to budget reductions and declining circulation.

The **Virginia Relay** system administered by DDHH can be accessed by dialing 7-1-1 on any phone. Traditional relay service for individuals with hearing or speech impairments uses an intermediary confidential Communications Assistant who converts text messages created on a TTY or similar device to voice and vice versa. As noted earlier, newer CapTel technology for individuals who have speech impairments but can still hear or who still have partial hearing ability transmits both voice and text. Individuals who use these services are encouraged to complete a Relay Choice Profile that automatically notifies the Communications Assistant of their calling preference. **Video Relay Service** is a fast growing feature of Virginia Relay that enables sign language users to communicate in their native language using a special video device. DDHH outreach contractors across the state can provide information, demonstrate the use of videophones, and provide technical assistance.

Virginia Relay's 105 Communications Assistants, located at its center in Norton, provide relay service 24 hours per day for every day of the year. They can also provide technical assistance and respond to comments and suggestions from the system's users. By law, they must

communicate users' typed or spoken words exactly as provided and maintain absolute confidentiality about all conversations. While the relay service is free, individuals must still pay their telecommunications providers' usual call costs. Overall use of Virginia Relay declined by 13.7 percent from 1,908,328 calls during SFY 2007 to 1,647,424 in SFY 2010, and the number of traditional TTY-based relay calls has dropped by 58 percent since 2004. This trend is directly attributable to the emergence of internet and wireless alternatives to relay services that allow individuals to communicate directly using text messaging, video, and other technologies.

On April 15, 2011, the maximum amount of loans made by the **NewWell Fund** directly to individuals and home-based businesses for assistive technology or other adaptive equipment, when the applicant is the full guarantor, was increased from \$15,000 to \$22,500. For loans greater than that amount, it partners with SunTrust Bank, and applicants must meet SunTrust's normal underwriting standards. When an applicant is unable to meet SunTrust's requirements on his or her own, the NewWell Fund may guarantee the loan. For this to happen, the applicant must first be rejected by the bank, then provide the NewWell Fund with satisfactory assurances of creditworthiness and ability to repay the loan. In determining whether these assurances are satisfactory, the NewWell Fund will overlook credit issues related to the applicant's disability. Loan application forms are available at www.atlfa.org/loanapplication.htm.

Resources supporting NewWell Fund loans include federal grants, state appropriations, and matching public and private contributions. While it primarily uses these resources for loans to individuals with disabilities, some are set aside for repayment of defaults, as necessary, and to reduce interest rates on all loans, further reducing individuals' loan obligations. The table below summarizes NewWell Fund loan activities for the past five state fiscal years (SFY).

NEWWELL FUND LOAN ACTIVITY

State Fiscal Year	2006	2007	2008	2009	2010
Loan Requests Processed	232	232	231	205	231
Types of Loans Approved					
Direct Loans	75	56	65	74	92
Nonguaranteed Loans	24	27	33	6	15
Guaranteed Loans	28	22	24	9	9
Total Loans Approved	127	105	122	89	116

Source: NewWell Fund.

While the total number of NewWell Fund loan requests processed and approved has remained relatively stable over this period, the number of direct loans has increased over the entire period and by 64 percent from SFY 2007 to SFY 2010. Their proportion has also increased, and in SFY 2010, they made up 79 percent of all loans approved. During that year, AT purchased by loan recipients included 20 hearing aids, 67 adapted vehicles or vehicle modifications, 15 environmental or home modifications, eight mobility devices, two prostheses, three computers and related software, one piece of recreational or sports equipment, and one tool of trade.

Brain Injury (BI) and Spinal Cord Injury (SCI) Services: As the state's lead agency for planning and monitoring services for individuals with acquired brain injury, the **Department of Rehabilitative Services' (DRS) Brain Injury Services Coordination (BISC) Unit** manages specialized brain injury services offered through contractual agreements with nine providers that operate 12 programs statewide at a total cost of \$3.8 million. The unit also provides support, technical assistance, and training for public and private providers of brain injury services.

BISC staff serve as an initial point of contact for other DRS personnel and external customers who need resource or referral information about brain and spinal cord injuries in general or information about specific agency services for persons with neurotrauma. Typically, in order to effectively serve individuals with brain or spinal cord injuries, an interdisciplinary support team works with the individual and his or her sponsor or family members or caregivers, at the individual's discretion, to develop and achieve vocational and independent living goals. BISC staff also work closely with DRS field staff to resolve customer concerns regarding agency services for persons with brain and spinal cord injuries.

The DRS **Brain Injury Direct Services (BIDS) Fund**, which has had limited resources, served only 18 individuals in state fiscal year (SFY) 2005, 30 in SFY 2007, and 15 in SFY 2010. Due to anticipated budget cuts, BIDS Fund expenditures for SFY 2010 were limited. Funds in the amount of \$22,500 were transferred to serve four additional individuals through the Personal Assistance Services for Individuals with Brain Injury (PAS/BI) program. The remaining \$18,317 were used for other client services. To maximize use of the BIDS Fund in SFY 2011, the DRS Commissioner has directed that each of the 12 contracted brain injury services programs receive an additional \$5,000, a total allocation of \$60,000, to create a more efficient, effective way of accessing funds in a timely manner. DRS retained a small balance of the funds to purchase goods and services for those who meet eligibility requirements but are not served by a state-funded brain injury program.

The DRS BISC Unit has a collaborative relationship with the **Woodrow Wilson Rehabilitation Center's (WWRC) Brain Injury Services (BIS) Department** and **Spinal Cord Injury (SCI) Services** program. A WWRC staff member serves on the Virginia Brain Injury Council and another is involved in WWRC's strategic planning for brain injury services.

The table below shows the number of individuals with brain injury served by the BIS Department and SCI Services at WWRC for selected years between SFY 2005 and 2010. The SCI Services counts do not include individuals with spinal cord injuries who may have been served by other programs at WWRC.

**INDIVIDUALS RECEIVING BRAIN AND SPINAL CORD INJURY SERVICES
AT WOODROW WILSON REHABILITATION CENTER (WWRC)**

WWRC Department/Program	SFY 2005	SFY 2007	SFY 2010
Brain Injury Services	123	132	132
Spinal Cord Injury Services	148	166	200

Source: Department of Rehabilitative Services (DRS).

The number of individuals served by the WWRC BIS Department increased by 7.3 percent between SFY 2005 and SFY 2007, then remained stable for SFY 2010; however, at the end of both SFY 2007 and SFY 2010, it had a waiting list of 14 individuals needing but not able to receive services. In comparison, the number served by SCI Services grew by 12.2 percent from SFY 2005 to SFY 2007 and an additional 20.5 percent between SFY 2007 and SFY 2010. Improvements to WWRC's data system in SFY 2010 allowed it to also track individuals with spinal cord injuries receiving services from its programs other than SCI services, a total of 27 individuals in addition to the 200 reported above.

Community Rehabilitation Case Management (CRCM) Services: This **Department of Rehabilitative Services (DRS)** program links individuals with disabilities and their families to the services that they need, coordinating and monitoring service delivery both to ensure that clients' evolving needs are met and eliminate, reduce, or prevent personal and economic dependency. CRCM Services are provided at no cost to individuals who meet disability and financial eligibility requirements through a Richmond central office and regional offices in Abingdon, Christiansburg, Fishersville, Fredericksburg, Hampton, Lynchburg, Portsmouth, and Richmond (www.vadrs.org/cbs/ltrcm.htm).

The number of individuals who can receive CRCM Services varies from year to year due to the program's limited capacity and variability in individuals' service needs. The table below contains data from the DRS 2010-2012 *Agency Strategic Plan* for selected years between SFY 2005 and SFY 2010 plus the actual and percent change for that entire period.

**NUMBER SERVED AND ON THE WAITING LIST
FOR COMMUNITY REHABILITATION CASE MANAGEMENT SERVICES**

State Fiscal Year	2005	2007	2010	Change	Percent
Number Served	526	581	708	+182	+34.6%
Number on Waiting List	250	105	79	-171	-68.4%
Total	776	686	787	+11	+1.4%

Source: Department of Rehabilitative Services (DRS).

As show above, the number of individuals needing CRCM Services remained relatively steady between SFY 2005 and SFY 2010 but exceeded the capacity for services resulting in a waiting list. During this time, however, DRS was able to increase the number served by 34.6 percent, reducing the waiting list by 68.4 percent, nearly eliminating it.

Comprehensive Services Act (CSA): The state **Office of Comprehensive Services (OCS) for At-Risk Youth and Families'** objectives in administering the services provided under this statute are to: (1) ensure that services are consistent with state policies for family preservation and for treatment in the least restrictive environment, (2) intervene early with youth who are at risk of developing emotional or behavioral problems and their families, and (3) increase family involvement in service delivery and management. To achieve these objectives OCS encourages partnerships and collaborations between public and private agencies in the design and delivery of

services that are responsive to the unique strengths and needs of troubled youths and their families.

Localities are required to have at least two different interagency teams as part of the process for determining access to the CSA system but, otherwise, are permitted to develop their own policies and procedures. The **Community Policy and Management Team (CPMT)** has administrative and fiscal responsibility for managing the local and state pool of funds, developing local interagency policies and procedures for referral and assessment, planning long-range community services, conducting quality assurance and utilization reviews, and appointing members to the locality's **Family Assessment and Planning Team (FAPT)**. Some localities allow parents to contact the CPMT or FAPT teams directly, while others require a local agency to bring a case before them, and many require that one of its team's participating agencies serve as the point of contact for a family. To learn how to access CSA in a locality, individuals may call the CPMT Chairperson or CSA Coordinator in their areas (www.csa.state.va.us/index.cfm).

The FAPT team assesses the strengths and needs of the youth and families who are approved for referral to the team, develops **Individual Family Services Plans** that identify the services required to meet their unique needs, and makes recommendations to the CPMT for funding. If a family disagrees with the service plan that is developed, it may ask for a CPMT review; however, emergency services can proceed while this review is taking place. The FAPT, with the assistance of the family and the youth's case manager, is responsible for identifying providers for needed services. If a family's needs cannot be met by the participating agencies, and there are no other community resources available, the team may then use CSA pool funds to purchase services. Except where prohibited by state or federal law and regulations, parents may be required to make co-payments for services according to a standard sliding fee.

Effective July 1, 2009, all youth determined eligible for services through CSA must be evaluated using the **Child and Adolescent Needs and Strengths (CANS)** standardized assessment instrument. Youth already served through CSA on that date were evaluated with CANS at the time of their next regularly scheduled reassessment. Results of these assessments guide service planning for children and their families and enable tracking of progress on meaningful outcomes. They also improve identification of service gaps and promote resource development.

The requirement that some parents were required to relinquish custody of their children in order to receive services through CSA was identified as a key issue in previous editions of the assessment. In 2006, Virginia's Attorney General issued an advisory opinion (www.oag.state.va.us/OPINIONS/2006opns/05-095-Fralin.pdf) that foster care services, as defined by the *Code of Virginia* (63.2-905), include the full range of treatment services when a child is abused or neglected (63.2-100) or "in need of services" (16.1-228). The opinion further stated that constitutional and statutory provisions require that CSA services be provided to eligible children without requiring parents to relinquish custody and that the FAPT and courts, rather than just the courts, could make the determination that a child was "in need of services." This opinion

allowed families to seek mental health treatment for children with severe emotional or behavioral needs without going through the court system.

In SFY 2010, 369 children received services through CSA based on agreements between parents and agencies other than local social services departments designated by CMPTs. Under these “parental agreements,” the parents retained legal custody and the children were placed outside of the home for treatment of their emotional or behavioral needs. In many of these cases, FAPT determined the children to be “in need of services,” and in others, a court made the decision.

The following table shows the number of youth who received services under CSA for state fiscal years (SFYs) 2005, 2007, and 2010 by their source of referral.

YOUTH SERVED UNDER THE *COMPREHENSIVE SERVICES ACT* BY REFERRAL SOURCE

Referral Source	SFY 2005		SFY 2007		SFY 2010	
	#	%	#	%	#	%
Social Services	9,842	61%	11,735	63%	10,128	58%
Education	3,251	20%	3,790	20%	4,467	25%
Juvenile Justice	1,294	8%	1,322	7%	1,370	8%
Interagency Teams	1,027	6%	676	4%	226	1%
Community Services Boards	664	4%	662	4%	1,205	7%
Families	66	<1%	70	<1%	67	<1%
Health	2	<1%	6	<1%	8	<1%
Other Sources	101	1%	197	1%	97	<1%
Total	16,247	100%	18,458	100%	17,568	100%

Source: Office of Comprehensive Services (OCS) for At-Risk Youth and Families.

Historically, as shown above, most referrals to FAPT come from local social services departments and school divisions because youth in foster care or with special education needs are mandated populations for CSA. Collectively, these two sources accounted for more than 80 percent of referrals in SFYs 2005, 2007, and 2010, and while there was a decline of five percentage points in referrals by social services departments in SFY 2010, the number of referrals by school divisions increased by the same amount. During this time, referrals from the juvenile justice system, the next highest proportion, have remained stable. On the other hand, referrals from Community Services Boards (CSBs) have nearly doubled, from four to seven percent of the total, while referrals from interagency teams have declined from six to one percent of the total.

In total, the number of youth served under CSA rose by 13.6 percent from SFY 2005 to SFY 2007, then declined by 4.8 percent from SFY 2007 to SFY 2010. This decline is likely attributable to a number of factors, with the most significant being the Commonwealth’s interagency effort since 2007 to increase the number of youth receiving community-based services in their homes.

In 2008, the General Assembly approved the use of financial incentives for localities to reduce reliance on residential programs. Beginning January 1, 2009, to encourage the use of community-based rather than residential services, the required local matching payment rate for residential services was increased by 15 percent over the SFY 2007 base rate for amounts in excess of \$100,000 expended through June 2009 and by 25 percent for amounts exceeding \$200,000. A hold harmless provision was included to protect smaller localities that may experience one or two expensive residential placements in a year; however, due to budget challenges, the 2010 General Assembly eliminated this exemption for the first \$200,000 in residential services. This new rate structure enabled the state to obtain federal Title IV-E funds that can be used to provide greater assistance for foster and adoptive families, and effective October 2009, the legislature increased the Additional Daily Supervision (ADS) payment rate to foster and adoptive parents based on the increased supervision needs of children being served in the home rather than in residential programs.

During SFY 2008, 34 percent of all CSA services were provided in the community or in schools; 47 percent in family-like settings such as family foster homes and therapeutic foster homes; 17 percent in licensed residential settings such as intensive treatment services, group homes, or temporary shelter care; and less than one percent in psychiatric hospitals. In contrast, for SFY 2010, the percentage of CSA services provided in the community or schools grew to 42 percent, declined for family-like settings to 39 percent, increased slightly to 19 percent in licensed residential settings, and remained stable at less than one percent for psychiatric settings.

As noted in this chapter's introduction, OCS has worked closely with the Department of Social Services (DSS) to implement new **Children's Services Transformation** practices outlining the values and principles directing agency interactions with families and service providers. In March 2010, the CSA State Executive Council approved policy guidance implementing a "**Family Engagement Model**" and CSA funds have been allocated for Family Partnership Meetings structured to involve and engage a child's extended family and natural supports into decision-making for children in foster care or at risk of foster care placement.

Supporting these OCS efforts, staff at local social services departments have been trained to use the **Virginia Enhanced Maintenance Tool (VEMAT)** to assess a child's needs and the level of supervision needed to maintain the child in a foster home. Therapeutic foster homes operated by private agencies currently use VEMAT, and its use will be extended to those operated by public agencies. At the state level, the Department of Medical Assistance Services (DMAS) is implementing a demonstration grant creating a new **Children's Mental Health Waiver** (http://dmasva.dmas.virginia.gov/Content_atchs/mch/mch-cmh1.pdf) to help children in psychiatric residential treatment facilities, who are eligible for Medicaid, receive community-based health services and family supports.

Independent Living and Related Services: The 15 **Centers for Independent Living (CILs)** and their four satellite operations spread across 18 of the state's 23 planning districts work directly with individuals with disabilities to identify needs, plan services, and assist with access to local services that will reduce barriers to independent living. Individuals needing assistance

should contact the CIL office in or closest to their locality (www.vadrs.org/cbs/cilslisting.htm) to access services. At the time of this assessment, CIL locations included Norfolk, Hampton, the Eastern Shore, Richmond, Fredericksburg, Arlington, Manassas, Charlottesville, Winchester, Roanoke, Lynchburg, Abingdon, Grundy, Harrisonburg, and Big Stone Gap. Satellite service locations included Petersburg, Christiansburg, Arlington, and Hampton. The CIL located in Danville discontinued its operations in the spring of 2011 as a result of audit and evaluation findings determined through the monitoring processes described later in this chapter.

CIL staff, a majority of which are required by federal statute to be individuals with disabilities, help an individual develop a plan for independent living services that takes into account the level of independence that the individual wishes to obtain. The plan records mutual agreements on what services will be provided and how and when they will be delivered. If requested by the individual with a disability, the plan must be in writing.

The number of individuals served and hours of service by CILs has fluctuated in recent years due to changes in annual goals and funding source priorities. Statewide, approximately 8,000 individuals were served in state fiscal year (SFY) 2005 and more than 7,200 in SFY 2007. Over 100,000 hours of service were provided to more than 9,400 individuals in SFY 2008, and in SFY 2010, more than 9,000 individuals received more than 80,000 hours of service.

Department for the Blind and Vision Impaired (DBVI) staff provide intake and make referrals for the agency's **Rehabilitation Teaching/Independent Living (RT/IL) Program** at six regional offices located in Bristol, Fairfax, Norfolk, Richmond, Roanoke, and Staunton. RT/IL staff work directly with individuals needing assistance to explain services, assist them in establishing eligibility, educate them on available resources, and refer them to appropriate DBVI programs or other community services. Orientation and mobility training, which has a direct impact on an individual's success in school, employment, and community living, is provided through the **DBVI Vocational Rehabilitation, Rehabilitation Teaching, and Education Services** program. For some service recipients, independent living and orientation-to-blindness skills training occurs at the **Virginia Rehabilitation Center for the Blind and Vision Impaired**. Individuals may also be referred to programs in other states when those programs can better meet their needs.

The number of individuals receiving orientation and mobility training decreased from 930 in state fiscal year (SFY) 2005 to 859 in SFY 2007 and 562 in SFY 2010, a total decline for the period of 39.6 percent. Most of this decline occurred between SFY 2007 and SFY 2010, a 34.6 percent drop, primarily due to DBVI's inability to fill vacancies for four of its 14 Orientation and Mobility Specialist positions because of lack of funding.

DBVI's **DeafBlind Services** program, which ensures that individuals with both vision and hearing impairments are full participants in all of its major programs, served 204 individuals in SFY 2005, 206 in SFY 2007, and 156 in SFY 2010. While the number served by this program was stable from SFY 2005 to SFY 2007, DBVI's recent inability to fill a vacancy for the program's director due to budget constraints resulted in 23.3 percent drop in the number served

over the entire period. During this time, DBVI's remaining DeafBlind Services specialist was able to provide services for individuals only in the western half of the state.

Individuals who cannot see with conventional glasses can obtain vision examinations and follow-up services from a statewide network of providers managed by DBVI's **Low Vision Services** program. As appropriate, those examiners refer individuals for follow-up assessments, counseling, and training. Training can occur in school, home, or other appropriate settings and includes the use of prescribed low vision optical aids. The DBVI Rehabilitation Teachers also provide case management to low vision customers being served through the Older Blind Grant Program. As above, budget constraints have had an impact on the number of individuals whom DBVI has been able to serve through this program, which dropped 22.6 percent from 1,200 in SFY 2005 to 929 in SFY 2007, then rose slightly by 2.6 percent to 953 in SFY 2010.

(Non-Waiver) Intellectual Disability Services: As noted previously, the **Department for Behavioral Health and Developmental Services (DBHDS)** is the state's designated administrative agency for intellectual disability services. For delivery of services, DBHDS contracts with local **Community Services Boards (CSBs)** that serve as the single point of entry into the state's mental health, intellectual disability, and substance abuse services system. CSBs are created by municipalities, for the most part, as independent authorities rather than as departments of city or county government. They are required to "provide individualized, effective, flexible, and efficient treatment, habilitation, and prevention services in the most accessible and integrated setting possible." Because each CSB is unique, reflecting its own community and available local resources and delivering its own mix of services directly or through contracts with numerous private providers, the availability of and eligibility for services varies widely among CSBs.

To receive services from a CSB, an individual is first "admitted" or "enrolled" and a medical record is opened in a face-to-face process. This admission is for services in general, not for any particular program, and by enrolling, the individual expresses his or her willingness and intention to receive services through the CSB. Next, an assessment of the individual's needs is made and eligibility for specific services addressing those needs is determined. Depending on specific needs, an **Individualized Services Plan (ISP)** or **Plan of Care (POC)** is developed that guides the implementation of needed services.

The table below shows the unduplicated number of individuals receiving core intellectual disability services for selected state fiscal years (SFYs) 2004 through 2009 from CSBs, as well as the amount and percentage of change from the previous year. As indicated, the total unduplicated number served increased from SFY 2004 to SFY 2006, by 12.4 percent for the entire period, with a significantly slower rate of growth in the second year. The number then dropped a total of 34.8 percent from SFY 2006 to SFY 2009 with most of that decrease occurring in the last year.

**PERSONS RECEIVING CORE INTELLECTUAL DISABILITY SERVICES
FROM COMMUNITY SERVICES BOARDS**

State Fiscal Year	Persons Served	Change	Percent
2004	23,925	----	----
2005	26,050	+2,125	+8.9%
2006	26,893	+843	+3.2%
2008	25,053	-1,840	-6.8%
2009	17,530	-7,523	-30.0%

Source: Department of Behavioral Health and Developmental Services (DBHDS), *Comprehensive State Plans* for 2006-2012, 2008-2014, and 2010-2016.

The DBHDS *Comprehensive State Plans*, from which the data above was drawn, also provide extensive information on waiting lists for services based on a point-in-time survey of CSBs regarding individuals who have sought any intellectual disability service and been assessed by their CSB as needing service. The results of these surveys, covering January to April each year and considered to be conservative estimates, appear in the table below featuring the unduplicated number of adults and children waiting for services during the 2005, 2007, and 2009 survey periods, by the length of time they have been waiting, plus the amount and percentage of change for the entire period. A majority of those on CSB waiting lists were receiving some type of service by their CSB, but need other additional or more intensive levels of services or supports. Data for 2010 will not be available until release of the next edition of the DBHDS *Comprehensive State Plan* in the fall of 2011.

**PERSONS WITH INTELLECTUAL DISABILITIES AWAITING SERVICES
FROM COMMUNITY SERVICES BOARDS**

Wait Time	2005	2007	2009	Change	Percent
Less than 1 month	190	199	57	-133	-70.0%
1 to 3 months	1,033	683	766	-267	-25.8%
4 to 12 months	962	905	1,048	+86	+8.9%
13 to 24 months	735	918	1,112	+377	+51.3%
25 to 36 months	583	768	709	+126	+21.6%
37 to 48 months	392	524	608	+216	+55.1%
49 to 60 months	400	417	500	+100	+25.0%
61 to 72 months	168	321	387	+219	+130.4%
73 or more months	711	1,229	1,209	+498	+70.0%
Not Reported	42	28	62	+20	+47.6%
Total	5,216	5,992	6,458	+1,242	+23.8%

Source: Department of Behavioral Health and Developmental Services (DBHDS), *Comprehensive State Plans* for 2006-2012, 2008-2014, and 2010-2016.

As indicated, both the number waiting for intellectual disability services from CSBs and the typical length of their waiting time increased from 2005 to 2009. While the number waiting for one year or less (29 percent of the total in 2009) decreased by 314 (a 14.4 percent reduction),

the number waiting one to five years (45 percent of the total) increased by 819 (38.8 percent) and for more than five years (25 percent of the total) by 717 (plus 81.6 percent).

Based on these survey results, the DBHDS *Comprehensive State Plan* for 2010-2016 reports that the following services were most often needed by both children and adults with intellectual disabilities who had been on the waiting list for more than 48 months:

- Supportive services including supportive living, in-home, personal assistance, and companion services;
- Case management; and
- Residential services including supervised residential and intensive (congregate) services.

The surveys also identify the number of children and adults with intellectual disabilities who are not receiving any CSB services, an additional measure of the unmet need for services. In 2005, there were 938 individuals who were not receiving any services. This count increased to 1,114 in 2007 and to 1,342 in 2009, an increase for the entire period of 43.1 percent, or 404 individuals.

Interpreter Services and Related Programs for the Deaf and Hard of Hearing: The state **Department for the Deaf and Hard of Hearing (DDHH)** coordinates requests for qualified interpreters for persons with hearing or speech impairments from individuals, state courts, state agencies and institutions of higher education, local government agencies and legislative bodies, and other public and private organizations across the state. In state fiscal year (SFY) 2010, the **DDHH Interpreter Services Program** contracted with 60 state agencies and institutions of higher education to directly coordinate their needs through referrals to 64 contracted sign-language interpreters. Agencies needing services provide DDHH with the name of the individual to be served (if known), the nature of the assignment, and their billing information. Individuals needing interpreter services to conduct certain Department of Motor Vehicle (DMV) business transactions or to attend 12-Step meetings or funerals may also contact DDHH directly for assistance, with the latter two services provided at no cost.

For others needing assistance, DDHH compiles and provides a statewide *Directory of Qualified Interpreters and Interpretive Services Coordination* containing contact information for only those interpreters who meet state “Qualified Interpreter” requirements. Generally, these interpreters act as individual contractors, with those employing them responsible for their fees and expenses to provide interpretive services at a specific place and time for a predetermined number of hours. When an individual has been denied interpreter services by private providers or others covered by the *Americans with Disabilities Act (ADA)*, DDHH can provide fact sheets on effective communications that the individual can share with the provider. It also encourages the individual to have the provider contact them directly for additional information and assistance in locating a private interpreter.

DDHH coordinated 2,672 requests for interpreter services from state and local agencies and state courts in SFY 2007. In SFY 2010, it received more than 2,258 requests, of which it

was able to meet 99.65 percent. More specific comparison of requests between state fiscal years is not possible because of changes made in SFY 2010 to how requests are processed and counted. In the past, multi-date assignments were counted as separate requests; however, they are now processed as a single request.

Omnibus Budget Reconciliation Act (OBRA) Services: The Departments of Medical Assistance Services (DMAS), Rehabilitative Services (DRS), and the Behavioral Health and Developmental Services (DBHDS) collaborate in implementing the provisions of this statute, and its evaluation, self-determination, discharge planning, and service provision requirements for states were covered in the earlier section of this chapter on eligibility. Once an individual qualifies for OBRA services, DBHDS is administratively responsible for contracting with DRS and local Community Services Boards (CSBs) for distribution of the funds covering those services. DRS Community Rehabilitation Case Management (CRCM) Services staff operating out of DRS field offices or CSBs provide or coordinate services, and for individuals wishing to transition from an institution to a community setting, DRS Community Rehabilitation Specialists work with social workers, Centers for Independent Living (CILs), and other resources to ensure that they receive services appropriate to their choices about where they will live and how their needs can best be met. These decisions are usually influenced by the availability of housing and community supports available through Medicaid Home and Community Based Services (HCBS) Waivers or other sources. In most cases, support coordination may be continued by a Community Rehabilitation Specialist if an individual is not receiving case management through a Medicaid HCBS Waiver or other program; however, OBRA funding for that support does not extend beyond the one-year transition period.

The number of individuals assessed by DBHDS and receiving services by DRS under OBRA in selected state fiscal years (SFYs) between 2005 and 2010 and the amount and percentage change for the entire period are shown below. DBHDS data originally reported in the 2008 edition of this assessment has been revised in this edition.

**INDIVIDUALS ASSESSED OR SERVED
UNDER THE *OMNIBUS BUDGET RECONCILIATION ACT***

Agency	SFY 2005	SFY 2007	SFY 2010	Change	Percent
Assessed by DBHDS	350	390	395	+45	+12.9%
Served by DRS	224	188	127	-97	-43.3%

Sources: Department of Rehabilitative Services (DRS) and Department of Behavioral Health and Developmental Services (DBHDS), respectively.

While the number assessed by DBHDS under OBRA increased between SFY 2005 and SFY 2010 by 12.9 percent, the number receiving services by DRS declined for the same period by 43.3 percent. Rates of change were also in contrast, with a greater increase in DBHDS assessments prior to SFY 2007 (11.4 percent versus 1.3 percent) and a greater decline in those receiving services by DRS after SFY 2007 (16.1 percent before versus 32.4 percent after).

(Non-Waiver) Personal Assistance Services (PAS): Regardless of their source or funding, personal assistance services facilitate community inclusion and greater independence for individuals with disabilities who require assistance with certain nonmedical physical and personal needs. Individuals receiving **State-Funded PAS** or **PAS for Individuals with Brain Injury (PAS/BI)** from the Department of Rehabilitative Services (DRS) have a direct employer-employee relationship with their personal attendants (PAs). As with consumer-directed PAS offered through the Medicaid Home and Community Based Services (HCBS) Waivers described in an earlier chapter of this assessment, the person with a disability or someone assisting them recruits and hires a PA, provides training, establishes work schedules and duties, directs the PA's work, authorizes timesheets for payment, and terminates the PA if necessary. To learn more about handling these responsibilities effectively, the individual with a disability must participate in PAS orientation training.

DRS staff review PAS applications, conduct initial eligibility screenings, and authorize related activities by the Centers for Independent Living (CILs) which are responsible for conducting needs assessments, orientation for persons with disabilities, and reassessments as well as providing other support services. DRS also reviews PA hiring packets for completeness and accuracy, calculates and approves the number of PAS hours that the individual may receive, and determines final eligibility. Following DRS review and approval of timesheets, verification of employment and earnings, and payroll preparation, a contract payroll provider handles payments, taxes, and earnings reports. As noted earlier, **Vocational Rehabilitation PAS (VR-PAS)** provided as necessary by DRS and the Department for the Blind and Vision-Impaired (DBVI), which may be either consumer- or agency-directed, is covered in the Employment chapter of this assessment.

The following table summarizes the number of persons receiving or on the waiting list for PAS provided by DRS for state fiscal years (SFYs) 2005, 2007, and 2010.

PERSONAL ASSISTANCE SERVICES (PAS) PROVIDED BY DRS

PAS Program	SFY 2005		SFY 2007		SFY 2010	
	Served	Waiting	Served	Waiting	Served	Waiting
State-Funded PAS	166	53	166	54	122	94
PAS/BI	8	7	6	2	5	3
VR-PAS	46	N/A	62	N/A	45	N/A

Source: Department of Rehabilitative Services (DRS).

Over this time period, the number of individuals served by all three DRS PAS programs has declined; although the number rose temporarily for VR-PAS in SFY 2007 before returning to approximately the same number in SFY 2010 as in SFY 2005. Both the number served and on the waiting list for PAS/BI are relatively small and thus subject to fluctuation, and there is no waiting list applicable ("N/A") for VR-PAS. For the years shown, the combined number served and on the waiting list (219, 220, and 216, respectively) for State-Funded PAS reflected an essentially unchanged need for these services. As a result, when the number served by State-

Funded PAS dropped by 26.2 percent from SFY 2007 to SFY 2010, the number on the waiting list rose by 74.1 percent, after having been stable from SFY 2005 to SFY 2007.

Services for the Elderly Population: The **Virginia Department for the Aging (VDA)** is responsible for coordination, technical support, and oversight of independent local **Area Agencies on Aging (AAAs)** and other contractual partners that deliver services for Virginians who are ages 60 and over or have disabilities and their families. VDA ensures that services are available statewide, develops and monitors service quality standards, and as both an educational and outreach resource, acts as a central referral agency for direct services provided by the 25 AAAs and 20 other community-based organizations.

AAAs typically receive requests for information or services by phone, then follow-up with person-to-person assessments as indicated. In areas where **No Wrong Door** aging and disability resource connections, described in more detail below, have been established among service agencies, AAAs can enter an applicant's information into a shared electronic database to expedite their receipt of services and coordination of their providers. While many AAA services, such as information and referral, are offered free of charge, some in-home and other services are provided on a sliding fee scale based on ability to pay.

Collectively, VDA, the AAAs, and their contracted partners provided services for 59,126 individuals in state fiscal year (SFY) 2005, to 58,873 in SFY 2006, to 58,241 in SFY 2007, and to 58,045 in SFY 2009. Waiting lists are maintained by some local programs where the number of requests for services exceeds the number that they are contracted to serve.

The **Public Guardianship Program** is one of the services administered by VDA through contracts with local agencies. Initial identification of individuals needing assistance, regardless of age, is made by local adult care facilities, the Adult Protective Services divisions of local social services departments, hospitals, and other organizations that serve persons who are indigent and may be incapacitated. They forward relevant information to a multi-disciplinary panel of the local guardianship program that determines whether it can best provide guardianship services. If so, the referring agency, either independently or with the assistance of a city or county attorney or volunteer counsel, requests a guardianship or conservatorship hearing by the Circuit Court. The judge may require specialized evaluations of the individual to obtain additional medical, psychiatric, psychological, or social information.

If the court finds the person to be incapacitated and in need of a guardian or conservator, the judge has flexibility in establishing the type of guardianship or conservatorship to preserve as much of the individual's independence as possible. They may be established on an emergency or temporary basis, applicable for a limited time or to decisions that correct conditions causing the emergency, or they may be limited to situations when decisions are needed about specific issues, such as health care or certain monetary matters. A standby guardian can also be designated who will assume the role after the death of the person currently responsible for care of another. Other legal alternatives to guardianship and conservatorship that can be exercised in Virginia include power of attorney, advanced medical directives (commonly called "living wills"), representative

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

After approval by the court, the local guardianship program takes responsibility for the incapacitated person and acts on his or her behalf consistent with the specific tenets of the guardianship. An individual may petition the court at a later date to end the guardianship, and a judge may terminate the guardianship if the individual is able to show that he or she can care for and manage his or her own affairs. In some circumstances, the judge may appoint another person or entity to be guardian or conservator.

Based on available funds, VDA designates a maximum number of individuals who can be served annually by each local guardianship program. Local programs do not exist in all areas of Virginia, and in 2010, all local programs were at capacity and some now have waiting lists. At the end of SFY 2010, the state's 15 local guardianship programs had a total capacity to serve 601 individuals, of which 249 slots were limited to individuals served through the state Department of Behavioral Health and Developmental Services (DBHDS). This number has been stable after a period of growth, with 212 served in SFY 2005, 580 in SFY 2007, and 601 in SFY 2009.

Due to state budget cuts, 18 guardianship slots were eliminated in state fiscal year (SFY) 2010, and in SFY 2012, additional slots are expected to be eliminated. According to VDA, reductions in available guardianship slots mostly impact individuals who reside in institutions and are ready for transition to a community setting, but need a public guardian in order to make the transition. A 2007 study by the Virginia Tech Center for Gerontology, the most recent analysis available, estimated that 1,441 persons statewide were indigent and incapacitated in SFY 2008 and had no one willing to act as a guardian (also referred to as a substitute decision-maker). The study projected that the number needing public guardianship services would reach 1,707 in SFY 2010.

The statewide **No Wrong Door** initiative has already been mentioned above and in several other places in this assessment. To improve access to services and technical assistance for both older adults and individuals with disabilities and their families, VDA has prioritized development and expansion of local aging and disability resource connections, led by AAAs, that create an internet-based, virtual "single point of entry" for accessing services. Between SFYs 2006 and 2008, VDA contracted with ten AAAs for pilot No Wrong Door projects, and during SFYs 2009 and 2010 an additional five AAAs became involved. Integration of the remaining ten AAAs over the next year will complete statewide coverage.

These local No Wrong Door networks of public and private agencies connect to a statewide database and eliminate the need for individuals and their families to contact multiple providers or complete duplicative forms, reducing their frustration and long waits to obtain needed services. This evolving model relies heavily on interagency cooperation and coordination among Centers for Independent Living (CILs), Community Services Boards (CSBs), social services and health departments, and other public and private service providers.

A uniform statewide technology platform enables these providers to share up-to-date client information, streamline eligibility determinations, make referrals between agencies more easily, better coordinate services, and track outcomes. Statewide oversight establishes the protocols needed to ensure that providers' and their clients' privacy is protected and that information is shared with their consent.

At the individual level, No Wrong Door puts information and tools directly in the hands of consumers through its interactive online portal, **Virginia Easy Access**. This website and its support network, described in more detail in the Information and Advocacy appendix to this assessment, were created through a public-private partnership of the Commonwealth of Virginia, SeniorNavigator, and 2-1-1 Virginia. Virginia Easy Access is a self-directed way for individuals to obtain information about the community options available to best match their long-term care needs. Unfortunately, as some citizens including members of the General Assembly have noted, this relatively new system still has user-friendliness and reliability issues, and the information that it contains is not comprehensive. For example, it lacks information and resources specifically addressing long-term care needs for children. To help address user-friendliness issues, especially for individuals who do not have a computer or internet access or who need assistance in accessing Virginia Easy Access online, **VirginiaNavigator Centers** are being established. There are currently over 200 centers across the state in partnership with local libraries, community centers, faith-based organizations, and other agencies that serve as information and referral resources.

VDA is also responsible for administering the **Community Living Program**, similar to the Program of All-Inclusive Care for the Elderly (PACE) described below, that helps aging individuals at risk of nursing home placement remain in their homes and communities. Ten AAAs are involved in this program, conducting extensive outreach for participants through various local service providers, advocacy groups, professional organizations, and community events. Individuals enrolled in the program or their caregivers will be asked by their AAA to participate in a survey interview regarding the impact of using self-directed services. The Virginia Tech Center for Gerontology, which is serving as external evaluator for the program, will report on the survey's results. From September 2009 through September 2011, the Community Living Program provided up to \$1,200 per person, per month of consumer-directed services for 95 older Virginians.

To obtain information or services from the **Older Blind Grant Program** administered by the **Department for the Blind and Vision Impaired (DBVI)**, older Virginians can contact any one of the agency's regional offices mentioned earlier or call its toll-free number, 800-622-2155. Staff at those locations can explain available services, assist in establishing eligibility, and make referrals to specific DBVI programs or other community resources as appropriate. Funds from this program supported services for 2,306 individuals in state fiscal year (SFY) 2005, for 2,178 in SFY 2007, and for 1,602 in SFY 2010. Over this period, the number served declined by a total of 30.5 percent. Following a small decline of 5.6 percent from SFY 2005 to SFY 2007, DBVI reports that an increase in the number of private practices serving individuals with low

vision reduced the number of referrals to the Older Blind Grant Program and contributed to the much larger drop of 26.4 percent between SFY 2007 and SFY 2010. DBVI is currently working on strategies to better inform optometrists, ophthalmologists, and other eye-care professionals of the array of services available through this program.

The **Program of All-Inclusive Care for the Elderly (PACE)** enables individuals ages 55 and over to “age in place.” Services are provided by designated agencies contracted by the **Department of Medical Assistance Services (DMAS)**. Prior to implementation of new PACE services in a locality, DMAS offers training on the program to all screeners and hospitals in the covered area, who then work with DMAS to identify all eligible individuals in that area and offer them PACE services. PACE coverage has gradually expanded since November 2007 and now includes seven operations in various areas of the state. Three additional locations are planned for Northern Virginia, Roanoke, and Charlottesville. Existing operations at the time of this assessment were:

- Sentara Senior Community Care (SSCC) serving individuals in the Hampton Roads area;
- Riverside at the Peninsula serving Newport News, Poquoson, the southeastern part of York County, and other parts of Hampton Roads;
- Mountain Empire PACE in Big Stone Gap serving the counties of Lee, Norton, Wise and Scott;
- AllCare for Seniors PACE in Cedar Bluff serving the counties of Tazewell, Buchanan, Dickerson and Russell;
- Riverside PACE in Richmond serving that city, portions of Petersburg and Henrico County, and the counties of Chesterfield, Goochland, Powhatan, New Kent, and Hanover;
- Centra Health PACE in Lynchburg serving that city and the counties of Bedford, Campbell, Nelson, Appomattox and Amherst.

As PACE coverage has expanded, so has the number of individuals served by the program, from 123 statewide in state fiscal year (SFY) 2007 to 626 in SFY 2010, with an average annual cost for PACE services in that year of \$25,620 per person. DMAS has identified elderly individuals with a documented diagnosis of intellectual disability (ID) as a growing subpopulation of PACE clients, 36.3 percent of the 509 receiving services as of June 1, 2010. Of the total of 185 individuals with ID served statewide on that date, 92 (49.7 percent) were served by PACE operations in the Tidewater area (Hampton, Virginia Beach, and Portsmouth).

D. Available Community Supports

As noted in the introduction to this chapter, it would be impossible to cover all of the available community supports in this assessment. The programs and services described below are subject to the eligibility and access procedures described in the preceding sections, and additional services not described below may be available from these agencies.

Assistive Technology (AT) and Related Services: Available AT devices, services, and funding sources vary among the **Department of Rehabilitative Services' (DRS) Virginia Assistive Technology System (VATS)** regional sites but generally include AT loans, training and demonstrations, information and technical assistance, and public awareness outreach. To help individuals make informed decisions about the use of AT, staff at the sites can provide more detailed guidance the application and benefits of specific devices and services, including what gently used, donated equipment may be available through **Virginia Reuse Network (VRN)** recycling programs coordinated by VATS.

The outpatient clinics and outpatient programs at DRS' **Woodrow Wilson Rehabilitation Center (WWRC)** provide a variety of AT services for adolescents and adults with disabilities who desire employment, including specialized and individualized computer technology, vehicle modification recommendations, customized rehabilitation engineering and fabrication, augmentative or alternative communication, customized seating systems and mobility enhancement, assistive listening devices, and adaptive devices for daily living and recreation. WWRC also provides the specialized training in AT use critical to successful integration of assistive technology into an individual's daily functioning. For example, its ten-day, intensive, residential Empowerment through Communication (ETC) program assists individuals in improving their communicative competence using alternative/augmentative communications (AAC) devices.

The **Department for the Deaf and Hard of Hearing's (DDHH) Technology Assistance Program (TAP) Loan-to-Own (L2O)** program provides information, referral, and technical assistance services and distributes TTYs, captioning telephones, amplified phones and handheld devices, signalers, speech amplifiers, and specially requested equipment for persons with both a hearing and vision loss. Services of DDHH's free **Virginia Relay** system that provides individuals who are hearing or speech impaired with assistance in using a telephone was described in earlier sections of this chapter.

The Assistive Technology Loan Fund Authority's **NewWell Fund** low-interest loans to individuals can be used for vocational and recreational equipment, hearing aids, specialized computer software, home or vehicle modifications, or any other personal AT equipment and associated training as long as it relates to the person's disability. Loans for home-based businesses are limited to business-related equipment, inventory, or supplies. The NewWell Fund can also arrange for and fund consumer counseling for loan applicants who need application assistance and for assessments related to obtaining AT equipment when alternative funding sources are not available.

Brain Injury (BI) and Spinal Cord Injury (SCI) Services: The **Department of Rehabilitative Services' (DRS) Brain Injury Services Coordination (BISC) Unit** contracts with nine regional providers for case management services, "clubhouse" day programs, and regional resource coordination. The BISC Unit, itself, assists DRS offices in resolving consumer concerns and provides support and technical assistance to other DRS and community-based brain injury services programs through direct training for vocational rehabilitation field staff and

community partners and sponsorship of their attendance at specialized training conferences and workshops.

The **Brain Injury Direct Services (BIDS) Fund** administered by DRS pays for short-term services for a small number of eligible individuals with acquired brain injury each year. These services are typically provided on an outpatient basis in community settings, cannot be funded by other means, and include neuropsychological assessment and counseling; neurobehavioral assessment and intervention; medical, speech, physical, occupational, cognitive, and other rehabilitation therapies; assistive technology (AT) assessments, purchases of recommended AT equipment, such as wheelchairs and communications devices, and related training or services; and community support services such as life skills training. Assistance in transitioning to other community supports and training for employers and family members are provided as appropriate. Because of limited resources, the BIDS Fund does not pay for either residential services or inpatient medical rehabilitation services.

The DRS **Woodrow Wilson Rehabilitation Center's (WWRC) Brain Injury Services Department** and **Spinal Cord Injury Services** program engage in outreach to individuals with these disabilities and provide direct services for them. Services are similar for both programs and involve both the individual who has sustained the brain or spinal cord injury and his or her family when appropriate. Intervention, assessments, treatment planning, and service delivery by interdisciplinary teams comprised of staff at WWRC and partners from the community emphasize self-sufficiency, responsibility for managing personal and physical needs, and vocational preparation. Assessments include home and work accessibility, assistive technology needs, and independent living skills, as well as driving, vocational, and other evaluations, as indicated. Available therapies include occupational, physical, psychological, neuropsychological, speech/language, life skills, and cognitive. Rehabilitation nursing, dietary, pharmacy, radiology, laboratory, and other health care services; opportunities to interact with peers at various levels of rehabilitation; and chaplain services are also available. Both programs include referral to the **WWRC Life Skills Transition Program**, a comprehensive, on- and off-campus educational opportunity to develop interpersonal, independent living, pre-employment, and leisure skills and basic workplace literacy.

In the past, all of the services described above have been provided by WWRC on both a residential and outpatient basis; however, in April 2011, WWRC announced that certain outpatient services were being phased out over the next three months due to budget pressures. Plans include elimination of 13 positions providing medical services as well as physical, occupational, and speech/language therapies. Radiology and laboratory services will be outsourced. To allow WWRC staff to focus on individuals with disabilities who are in need of vocational rehabilitation services, current outpatient clients who are not involved in vocational rehabilitation will be referred to community providers for medical and related services.

Community Rehabilitation Case Management (CRCM) Services: As previously noted, CRCM specialists work collaboratively with eligible individuals, including those residing in nursing homes, to plan services and supports in the community that will enhance their quality of

life, independence, and if applicable, employment. By providing information, referrals, and support coordination, they link these individuals to assistive technology, support groups, medical care, social and recreation opportunities, housing, transportation, counseling, and other services and supports appropriate to their needs. The CRCM Services program also provides support coordination under the Medicaid Home and Community Based Services (HCBS) Individual and Family Developmental (DD) Waiver which is described in detail in the Medicaid chapter of this assessment.

Comprehensive Services Act (CSA): The **Family Assessment and Planning (FAPT) Teams** described earlier are responsible for identifying, planning, and coordinating services for CSA-eligible youth. No specific menu of services exists because services are tailored to the unique needs of each child and his or her family. Within statutory and policy guidelines, a full range of services is possible, including comprehensive assessments, crisis stabilization and intervention, behavioral aides, respite care, mentoring, mental health services, substance abuse services, intensive in-home services, specialized “wrap-around” services, therapeutic day treatment, afterschool services, vocational services, independent living services, special education private day programs, or residential care. Eligible youth, a large proportion of whom have mental health challenges, generally receive more than one of these services during the year, and the most frequently used in state fiscal year (SFY) 2010 were community-based services such as mentoring, intensive in-home services, intensive care coordination, out-patient therapy, parent education and skills training, and therapeutic foster care.

Independent Living and Related Services: Helping individuals develop personal and systems change advocacy skills is a fundamental part of the independent living mission, and as the primary resource for community living supports in Virginia, **Centers for Independent Living (CILs)** are required to provide certain core services including information and referral, peer counseling, advocacy, and independent living skills training. Most CILs provide additional services beyond their core responsibilities, such as linkages to housing resources, and to improve and expand employment opportunities for people with significant disabilities, they inform and advise local, state, and federal legislators and administrators, are involved in community planning and decision-making, and work with local governments and employers. Some CILs provide peer counseling as well as mentoring and skills training programs in schools, and many hold recreational events that bring together local residents with and without disabilities.

The **Department for the Blind and Vision Impaired’s (DBVI) Rehabilitation Teaching/Independent Living (RT/IL) Program** provides individualized needs assessments, adjustment counseling, information and referrals, and skills training through a variety of programs described earlier, including the **Rehabilitation Center for the Blind, Low Vision Services, and DeafBlind Services**. DBVI rehabilitation teachers are located across the state and generally provide these services in the individual’s home. They also educate family members and others who wish to be of assistance to an individual with vision impairment. Skills training programs cover self-advocacy and outreach, daily living and home management, and forms of communication including Braille. Assistive technology, rehabilitation engineering, and other

specialized services are provided as well, including visual examinations, optical aids, and follow-up services for persons who cannot see with conventional glasses that are offered through the Low Vision program. DBVI Orientation and Mobility training teaches the use of the long cane as a travel tool as well as specific techniques to allow individuals with vision impairment to establish and maintain orientation to their surroundings. DeafBlind Services provides additional specialized services, particularly in the area of communication, and provides guidance and technical assistance to other DBVI programs, other public and private organizations, and the general public regarding the unique needs of its target population.

(Non-Waiver) Intellectual Disability Services: As the Commonwealth's single point of entry for intellectual disability services, local **Community Services Boards (CSBs)** can provide eight categories of "core" services either directly or through contracts with other public or private service providers. CSBs are mandated to provide only emergency services and, subject to available appropriations, case management services. The other core services that CSBs may choose to offer include outpatient, residential, prevention, early intervention, employment, and day support services. As further described in the Community Housing chapter of this assessment, individual CSBs may provide various levels of residential services described as supportive, supervised, intensive, and highly intensive. Some CSBs also offer family support services such as behavior management and respite care.

Interpreter Services and Related Programs for the Deaf and Hard of Hearing: The **Virginia Department for the Deaf and Hard of Hearing (DDHH)** directly coordinates requests for qualified interpreters by state agencies, courts, and certain others as specified earlier in this chapter. It also compiles and distributes a *Directory of Qualified Interpreters and Interpreter Services Coordination* for use by any individuals and organizations statewide to identify and arrange interpreter services. DDHH's outreach program provides information and training for individuals and civic organizations on topics including improving sign language skills, using interpreters effectively, obtaining assistive technology, and coping with hearing loss.

Omnibus Budget Reconciliation Act (OBRA) Services: The services most commonly requested and used by individuals covered under OBRA who reside in nursing facilities or who are transitioning from nursing facilities to community settings have been support coordination (case management) and day support for socialization, communication, and community integration. They generally also receive personal assistance services along with other services as needed and appropriate. Those additional services may include crisis intervention; psychotherapy; individual and group counseling; training in behavior management, communication skills, independent living, and utilization of community resources; educational assistance, prevocational training, and supported employment; assistive technology and rehabilitation engineering; and transportation to and from service providers. OBRA also provides transition services for individuals moving from a nursing home to the community that are not covered under other entitlements but are necessary to ensure a smooth transition, such as needed home modifications, deposits for utilities, and assistive technology.

Services for the Elderly Population: The 25 Area Agencies on Aging (AAAs) collaborate closely with their local health and social services departments, nonprofit organizations, and other resources, resulting in service offerings that are unique and diverse. Services typically include adult day care; programs that check on individuals in their own homes to ensure that they are safe and well; meal programs and nutrition services; health and wellness information and screenings; chore, homemaker, and personal care services; home modification and repair; care coordination; insurance counseling; elder-abuse prevention; money management and counseling; and legal assistance. General information, referral, and ombudsman services are provided as well, along with education, recreation, social, and volunteer opportunities. Some AAAs also offer employment, home heating and cooling, and tax filing assistance; transportation to and from activity centers or other programs; and help in completing applications for services from other sources. A few AAAs administer housing programs for older residents and run Program of All-Inclusive Care for the Elderly (PACE) centers.

The Virginia Department for the Aging (VDA) contracts with the AAAs to provide the following specific programs:

- Employment services for low-income older adults through the **Community Service Employment Program**,
- Benefits counseling for Medicare beneficiaries and others through the **Virginia Insurance Counseling and Assistance Program (VICAP)**,
- The **Virginia Public Guardianship Program** discussed in detail throughout this chapter, and
- **Virginia GrandDriver**, a resource for older drivers and their families or caregivers.

In addition to these contracted services, the VDA **Community Living Program** provides eligible participants with a monthly allotment to purchase needed supports such as assistive technology, a Personal Emergency response system, disposable medical supplies, transportation, personal care, homemaker services, home modifications, and nutritional supplements. Participants can also save up to \$5,000 from these allotments for the purchase of more expensive items or services, such as installation of a ramp for their home.

The **Department for the Blind and Vision Impaired's (DBVI) Older Blind Grant Program** offers a wide variety of services as well, including outreach; information and referral; advocacy; visual screening; eyeglasses and low vision aids; assistance with housing relocation; adaptive equipment to assist older blind Virginians to become more mobile and more self-sufficient; guide services for essential access to community resources; transportation; orientation and mobility services; peer counseling; volunteer reader services; adaptive skills training to assist in coping with daily living activities; and other essential supportive services for independent functioning in the home and community, including local independent living training workshops for consumers and their family members.

Using funds from the federal *American Recovery and Reinvestment Act* (ARRA), the Older Blind Grant Program began an initiative in June 2009 to provide visually eligible, computer literate older Virginians with accessible desktop computer systems and training in their use. With these systems, older individuals who are blind or vision impaired are once again able to independently access information and can communicate more effectively with others. The initiative is scheduled to continue until the federal “stimulus” funds are depleted or no later than September 30, 2011. As of January 2011, over 100 computers with appropriate assistive technology had been purchased for eligible recipients.

Each of the **Program of All-Inclusive Care for the Elderly (PACE)** sites listed in the previous section of this chapter provides the full scope of services under the Medicaid State Plan, which is described in the Medicaid chapter of this assessment. Each PACE participant receives a comprehensive assessment and treatment planning from an interdisciplinary team of professionals, all of whom have at least one year of paid experience working with the target population. The team also provides each enrollee with case management for all services provided or arranged by the PACE program.

E. Cost and Payment for Community Supports

Because of the number and complexity of agencies and initiatives that contribute to Virginia’s community supports system, a comprehensive discussion of specific allocation and payment mechanisms for every program is not feasible in this assessment. Extensive information about funding of state agency programs, however, can be found in the state appropriations bill and other documents available through the Department of Planning and Budget’s (DPB) website (www.dpb.virginia.gov) as well as in agency strategic plans posted to the Virginia Performs website (www.vaperforms.virginia.gov).

The table below contains data obtained from a variety of sources for state fiscal year (SFY) 2010 for many of the programs described in this chapter, and while limited, it can be helpful in understanding the range and levels of expenditures for community supports. Some programs were unable to respond to data requests in time for their information to be included in this assessment. When appropriate and possible, the number of individuals served and on waiting lists for services have been included. Notes follow the table clarifying certain details. Except as noted, Average Cost represents per capita cost, the total cost divided by the number served. “Not Applicable” (abbreviated as “N/A”) is indicated under Average Cost when expenditures by an agency or program cover multiple types of services for multiple individuals and cannot be determined on an average cost per person basis. Except as indicated in the notes, “Not Available” refers to situations where financial data was available for only the federal fiscal year (FFY) rather than the state fiscal year (SFY) or where a program was part of a larger initiative and the amount or designation of its funding and expenditures could not be separately determined.

SFY 2010 VIRGINIA EXPENDITURES FOR COMMUNITY SUPPORTS

Program or Service	Number Served	On Waiting List	State Funds	Federal Funds	Other Funds	Total Cost	Average Cost
Assistive Technology (AT) and Related Services^A							
NewWell Fund ^B	116	0	\$0	\$674,287	\$613,477	\$1,287,764	N/A
DDHH Technical Assistance Program (TAP) ^C	1,099	0	\$410,069	\$0	\$0	\$410,069	\$373
Virginia Relay ^D	1,647,424	0	\$0	\$0	\$10,226,176	\$10,226,176	\$6
Virginia Assistive Technology System (VATS)	4,845	0	\$0	\$481,673	\$229,020	\$710,693	\$147
Brain Injury (BI) and Spinal Cord Injury (SCI) Services							
Brain Injury Direct							
Services (BIDS) Fund	15	6	\$18,135	\$0	\$0	\$18,135	\$1,209
DRS Brain Injury Services Program Contracts ^E	11,800	100 (approx.)	\$3,821,000	\$0	\$0	\$3,821,000	\$324
WWRC BI Services ^F	132	14			Not Available		
WWRC SCI Services ^G	227	No List			Not Available		
Community Rehabilitation Case Management (CRCM) Services							
DRS CRCM ^H	708	79	\$507,643	\$0	\$0	\$507,643	N/A
Comprehensive Services Act (CSA)^I							
Mandated	16,193	No List	\$226,540,026	\$0	\$113,253,023	\$339,793,049	\$20,984
Non-Mandated ^J	1,375	Not	\$4,674,447	\$0	\$2,336,873	\$7,011,320	\$5,099
All CSA Services ^I	17,568	Available	\$231,214,473	\$0	\$115,589,896	\$346,804,369	\$19,741
Independent Living and Related Services							
Centers for Independent Living ^K							
	>9,000	No List	\$4,577,519	\$3,987,878	\$0	\$8,565,397	N/A
DBVI Rehabilitation Teaching/Independent Living (RT/IL) and Orientation and Mobility Services ^{L,M}							
	2,864	No List	\$1,672,535	\$1,762,156	\$85,000	\$3,519,691	N/A
DBVI DeafBlind Services ^L							
	156	No List	\$112,256	\$28,064	\$0	\$140,320	N/A
DBVI Low Vision Services ^L							
	953	No List	\$151,375	\$0	\$355,000	\$506,175	N/A
(Non-Waiver) Intellectual Disability Services							
Community Services							
Boards (CSBs) ^N	11,598	No List				\$117,563,717	\$10,137
(Non-Waiver) Personal Assistance Services (PAS)							
DRS Brain Injury PAS	5	3	\$77,659	\$0	\$0	\$77,659	N/A
DRS State-Funded PAS	122	94	\$2,276,131	\$0	\$0	\$2,276,131	N/A
DRS Vocational Rehabilitation PAS	45	No List	\$0	\$511,417	\$0	\$511,417	N/A
Omnibus Budget Reconciliation Act (OBRA)							
	127	0					Not Available
Services for the Elderly Population^O							
DBVI Older Blind Grant Program ^{L,P}							
	1,602	No List					Not Available
Program of All-Inclusive Care for the Elderly (PACE)	626	No List	\$6,160,268	\$9,877,921	\$0	\$16,038,189	\$25,620

- A. No specific funding allocation is designated for assistive technology (AT) services at the **Department of Rehabilitation Services' (DRS) Woodrow Wilson Rehabilitation Center (WWRC)**. Services are provided on a fee-for-service basis and are reimbursed by Medicaid, Medicare, DRS, and other sources. Therefore, no data for this program has been included in this table.
- B. Funding for the **NewWell Fund's** loan program comes from a combination of sources, including federal grants, state appropriations, and matching public and private contributions. The amount listed under other funds reflects loans made directly by SunTrust Bank. Average loan amount per person was \$11,101 in SFY 2010.
- C. The number served by the **Department for the Deaf and Hard of Hearing's (DDHH) Technical Assistance Program (TAP)** includes both persons receiving equipment and those receiving technical assistance. TAP costs include loaned equipment, equipment demonstrations, and information and referral services.
- D. The number served for **DDHH's Virginia Relay** program reflects the number of completed calls rather than individuals. Average cost is per call, not per person.
- E. There are two categories of **DRS Brain Injury Services Coordination (BISC) Unit** contract services: direct brain injury services for individuals, which served 3,000 individuals, and outreach, which served 8,800 individuals through public awareness, public information, and referral services. In addition to the amounts shown here, DRS brain injury services programs brought in \$2,021,100 in non-state resources during SFY 2010, including grants, donations, volunteer services, and donated equipment and other goods.
- F. Individuals served by the **WWRC Brain Injury Services Department** typically receive multiple other services in addition to brain injury services from WWRC; therefore, financial data specific to those services is not available.
- G. No specific funding allocation is designated for **WWRC Spinal Cord Injury Services**. Overall, approximately 70 percent of WWRC funding comes from federal Title I vocational rehabilitation funds, 20 percent from state general funds, and 10 percent from fees for service, special funds, or grants.
- H. The number served by **DRS Community Rehabilitation Case Management (CRCM) Services** includes 379 on active caseloads as well as 329 receiving only technical assistance, making calculation of an average cost for services per person inappropriate.
- I. Federal Social Services Block Grant funding for services under the **Comprehensive Services Act (CSA)** are provided through the Virginia Department of Social Services (DSS) and, for financial reporting purposes, are considered to be state funds as reported in this table. Local governments are the source of other funds.
- J. Local governments have the option of maintaining waiting lists for non-mandated children; therefore, information is not available on the total number of children needing CSA services or who may be on waiting lists for them.
- K. An average cost for services per person by the **Centers for Independent Living (CILs)** is not provided because the number served is an estimate and allocated funds cover both direct services for individuals with disabilities as well as public awareness, technical assistance, and

training activities directed at service providers, organizations, families, and other broad categories of constituents.

- L. **Department for the Blind and Vision Impaired (DBVI)** staff members provide multiple services for persons with disabilities through several different programs with expenditures for both personnel costs and purchases of tangible goods and services spread across those programs. As a result, a calculation of average cost per person served for each program is not possible.
- M. The number served includes 2,302 individuals who received services from the **DBVI Rehabilitation Teaching/Independent Living (RT/IL) Program** and 562 who received **Orientation and Mobility** services.
- N. Expenditure information for non-waiver services for individuals with intellectual disabilities was provided by the **Department of Behavioral Health and Developmental Services' (DBHDS) Office of Community Contracting** from SFY 2010 performance reports submitted by **Community Services Boards (CSBs)**. Information by funding sources was not available.
- O. SFY 2010 data was not available from the **Virginia Department for the Aging (VDA)** for programs that it administers. For the previous year, SFY 2009, expenditures for local services provided by Area Agencies on Aging (AAAs) and other contracted agencies totaled \$52,709,018, with an average cost per person of \$893. This included \$11,796,728 in state general funds, \$26,828,979 in federal funds, and \$14,083,311 from other sources. That same year, the Public Guardianship Program expended \$1,869,645 in state general funds at an average cost per person of \$3,111. The Long-Term Care Ombudsman program expended \$1,648,521 in SFY 2009, with \$286,574 coming from state general funds, \$816,289 from federal funds, and \$545,658 from other sources. This reflected a significant increase from SFY 2007 expenditures of \$1,156,246 for the ombudsman program.
- P. Funding for services through the **DBVI Older Blind Grant Program** comes from other DBVI programs listed above under Independent Living and Related Services.

F. Monitoring and Evaluation of Community Supports

All Virginia state government executive branch agencies are required to establish goals, objectives, and outcomes for their programs in strategic plans and performance measures posted to the Virginia Performs website (www.vaperforms.virginia.gov). Oversight procedures for the programs discussed in this chapter are covered below, with specific monitoring and evaluation results cited as available.

Assistive Technology (AT) and Related Services: Activities of the **Department of Rehabilitative Services' (DRS) Virginia Assistive Technology System (VATS)** are guided and overseen by the **Virginia Council on Assistive Technology** based on a three-year plan that must be submitted to the **Rehabilitation Services Administration (RSA)**, VATS federal funding source, for approval. Information on activities and events sponsored by VATS is collected and compiled on a routine weekly, monthly, quarterly, and annual basis. This includes quarterly reports from its regional sites and the Virginia Reuse Network on how many individuals received

recycled AT devices, their values had they been purchased, and the resulting cost savings. Quarterly reports also include summative evaluations from large training programs and conferences. To ensure accountability, this information plus the results of client follow-up and satisfaction surveys are compiled at the state level, compared to VATS three-year plan as part of its annual program report to RSA, and used to make modifications to the plan as indicated.

AT services provided by the **Durable Medical Equipment (DME) Program at DRS' Woodrow Wilson Rehabilitation Center** are accredited by the **Accreditation Commission for Health Care**. In addition, information is routinely gathered on specific individual satisfaction measures, and based on the results of calls to individuals who have received wheelchairs or other DME through the WWRC AT program, therapists are assigned to contact those individuals for troubleshooting and other follow-up. All quality assurance information is tracked in a database, reviewed semi-annually to determine ways to improve service delivery, and further reviewed annually by the **WWRC AT Center of Excellence Focus Group**.

Customer comments received by the **Department for the Deaf and Hard of Hearing's (DDHH) Technology Assistance Program (TAP)** are routinely documented, and concerns are forwarded, as needed, to the appropriate Outreach Specialist, Program Coordinator, or the agency's Director, who is responsible for quality assurance. Procedural changes in the **TAP Loan-to-Own (L20)** program have significantly reduced the time required to receive equipment from up to six weeks to just several days. The DDHH 2010-2012 *Agency Strategic Plan* reports that nearly 100 percent of customers were "satisfied" or "very satisfied" with services received based on a survey implemented in 2009.

DDHH is responsible for managing and monitoring telecommunications contracts for all **Virginia Relay** services (*Code of Virginia, 56-484.7*) and for annual reports to the **Federal Communications Commission** on contractor performance and consumer feedback, including a log of all consumer complaints. Virginia Relay service contracts include specific steps for ensuring vendor compliance and for their response to individual complaints. User comments are compiled daily by Virginia Relay contractors and reported monthly to DDHH. DDHH oversight also includes routine test calls by agency staff and contracted external, independent testers; onsite quality assurance visits; and reviews of monthly performance and statistical reports as well as feedback from system users and members of the **Virginia Relay Advisory Council**. The DDHH *Agency Strategic Plan*, mentioned above, notes challenges to further improvement of service delivery. Video Relay Services (VRS) remain unavailable in rural areas where broadband or DSL infrastructure does not exist, and where VRS is available, its use is often blocked by businesses' internet security firewalls.

Oversight for the **NewWell Fund** is provided by a Board of Directors, the members of which include the state Secretary of Health and Human Resources or his or her designee, a WWRC employee, a representative from a consumer lender, a certified public accountant, two individuals with investment finance experience, and six individuals with disabilities (*Code of Virginia, 51.5-56*). A revised Governance Manual and updated bylaws, approved by the Board in 2007, establishes policies and procedures for consistent delivery of the authority's programs.

The NewWell Fund must also comply with requirements of the federal **Rehabilitation Services Administration (RSA)**, including an annual external audit analyzing day-to-day organization, administration, and finances and an annual report describing program activities. As a part of that report, the authority must tabulate the types and amounts of loans issued by the demographics of loan applicants. In its 2006 RSA report, the NewWell Fund identified critical issues, primarily related to increasing public awareness of its programs and enhancing its marketing and outreach to people with disabilities, as a future central priority. Since then, it has rebranded the loan program that funds equipment, supplies, or inventory for home-based businesses operated by individuals with disabilities as the “HomeWorks” Loan Program. A new brochure was finalized for broad marketing and distribution in 2010, and expansion of the program is underway. At the time of this assessment, a routine audit of the NewWell Fund was also in progress.

Brain Injury (BI) and Spinal Cord Injury (SCI) Services: The manager of the **Department of Rehabilitative Services’ (DRS) Brain Injury Services Coordination (BISC) Unit** is responsible for oversight of services provided by that and other related DRS programs, including the 12 contracted direct services programs across the state. Staff of the BISC Unit also provide support for the **Virginia Brain Injury Council**. Expenditures, activities, and outcomes are routinely monitored; issues of significance or concern are reported to the Community Based Services Division Director and DRS Commissioner on a weekly basis; and written reports are submitted annually to the DRS Commissioner via the Virginia Brain Injury Council, as well as to the **Virginia Disability Commission** and the General Assembly. These required annual reports cover the number of people served, types of services provided, and success in leveraging non-state resources.

The Virginia Brain Injury Council meets quarterly and, as a policy advisory group, makes recommendations to the Commissioner on how best to disseminate allocated state funding. Two additional groups, the **Virginia Alliance of Brain Injury Service Providers** and the **Brain Injury Association of Virginia (BIAV)**, also work closely with the Council and BISC staff to ensure accountability in the expenditure of funds for brain injury services. Suggestions and concerns raised by these organizations, internally by DRS staff, and by other community partners are considered by the council and brought to the attention of the Division Director and DRS Commissioner so that policy and procedure changes or other appropriate actions, if feasible, can be taken.

Organizations contracted by DRS to provide brain injury services are required to comply with state fiscal policies and controls and must submit financial and narrative progress reports on a monthly, quarterly, and annual basis. Annual reports must include evaluations, such as consumer satisfaction surveys, available to the contractors from internal or external sources. The BISC Unit’s last internal audit was completed in 2006 and, while no significant findings or exceptions were noted, it was recommended that contract language be revised to require that providers submit an annual external audit and control self-assessment document to DRS. Although these reports had been submitted by providers, they were not previously stipulated by their contracts. Along with implementation of this recommendation, the expectation that

providers would be accredited by the **Commission on Accreditation of Rehabilitation Facilities (CARF)**, was also made a requirement of their contracts.

Prior to 2007, the BISC Unit hired external consultants to evaluate performance by contracted service programs every two to three years. While this practice continues, contractors have been required, beginning that year, to submit expenditure and outcome data via a new online SCORECARD system that enables DRS to monitor contract compliance as well as program efficiency and effectiveness in a more structured and routine manner. During the first year of SCORECARD field testing, it was found that the formula for calculating the percentages of goals achieved and overall ratings of whether a contractor's performance met, exceeded, or was below expectations needed adjustment so that all of the resulting scores did not exceed expectations. Once the formula was adjusted, SCORECARD results were more aligned with what would be expected across the various programs. The SCORECARD system also requires programs to submit narrative reports to the manager of the BISC Unit that highlight achievements and notable success stories and that also detail reasons for any performance measures that are below expectations. Inconsistencies exist among contracted programs in how they report on their activities using the SCORECARD system, and discussions were held in December 2010 to address those inconsistencies.

In 2007, the manager of the BISC Unit also initiated an annual two-day general meeting of directors, program managers, and fiscal specialists from the state-funded brain injury contract service providers to provide technical assistance on administrative and oversight issues, promote sharing of best practices and collaborative efforts to improve service delivery, and provide an opportunity for program staff to present issues or concerns. A second two-day meeting was held in 2008; however, due to budget reductions, no meeting was held in 2009 and only a one-day meeting was held in 2010.

Although there is no formal internal evaluation of the **Brain Injury Direct Services (BIDS) Fund**, information on the number of individuals that it serves and the types and costs of services that it funds are included in the annual reports by the manager of the BISC Unit to the DRS Commissioner and Virginia Brain Injury Council mentioned above. Procedures to identify and address concerns about the use of the BIDS Fund are similar to those for other BISC Unit and Community Based Services activities. Requests for goods and services costing more than \$1,000 are reviewed by both the program manager of the BIDS Fund and the manager of the Community Rehabilitation Case Management (CRCM) Services program as a check and balance on the use of the BIDS Fund, and DRS has reports that no concerns have been expressed to-date on its management or effectiveness.

In response to a request from the DRS Commissioner, the Virginia Brain Injury Council commissioned a 2009 "white paper" by brain injury experts from across the state on neurobehavioral treatment options and needs in Virginia. The study report, *Neurobehavioral Treatment for Virginians with Brain Injury: A Virginia Brain Injury Council Position Paper*, identified a model system of care based on best practices and proposed a three-level system of

care demonstration project to address the needs of individuals with brain injuries. It recommended:

- Creation of an ongoing interagency agreement between DRS and the Departments of Juvenile Justice (DJJ), Medical Assistance Services (DMAS), and Behavioral Health and Developmental Services (DBHDS) to address the needs for brain injury services systematically statewide;
- Interagency review and update of current licensing regulations for non-Medicaid residential services to ensure implementation of best practices in assessment and treatment;
- Expansion of community-based neurobehavioral treatment services for individuals with brain injury as a central component of the state's *Olmstead* community integration goals and planning processes; and
- Modification of state Medicaid policies to cover in-state neurobehavioral programs, including those not designated as skilled nursing programs, and creation of a Medicaid Home and Community Based Services (HCBS) Brain Injury Waiver.

To integrate data collected by other state agencies with its own and improve the delivery of pre-hospital and hospital emergency medical services, the **Virginia Department of Health (VDH)** was given responsibility in 2008 for monitoring the incidence, severity, and causes of traumatic injuries (*Code of Virginia*, 32.1-116.1). In response, VDH combined two existing DRS-maintained databases, the Traumatic Brain Injury Registry and the Spinal Cord Injury Registry, with its own Virginia Statewide Trauma Registry (VSTR) to create the comprehensive **Emergency Medical Services Patient Care Information System (EMS-PCIS)**. Following their response to a traumatic injury, all licensed emergency medical services are required to notify this system of the nature of the emergency call and type of medical emergency, their response time, the treatment provided to individuals of all ages who received a diagnosis of brain or spinal cord injury, and other data that the Medical Emergency Services Advisory Board determines needs to be collected.

VDH shares information from the new EMS-PCIS registry with DRS so that it can better develop and implement services for individuals with brain or spinal cord injuries, and VDH reports that DRS has recently been provided with direct access to the data subset related to head and spinal cord injuries, enabling DRS to access data provided by hospitals in real time as frequently as desired. DRS reports, however, that the new registry, unlike the previous VSTR system, does not collect information on individuals who are treated and released by emergency medical departments. As a result, individuals with mild concussions or brain injuries may not receive outreach information about available services, and the DRS BISC Unit is exploring other ways to reach the individuals who were not admitted to the hospital.

Prior to the implementation of the new EMS-PCIS registry, the VSTR system documented hospital admissions for 7,635 individuals in state fiscal year (SFY) 2008 and 7,969 in SFY 2009. DRS conducts outreach through a contract with the Brain Injury Association of

Virginia (BIAV), and its most recent mailing to 3,500 individuals was completed in December 2010.

Internal processes at **DRS' Woodrow Wilson Rehabilitation Center** govern program capacity and resource allocation, and guidance on services by the **Brain Injury Services (BIS) Department** and Spinal Cord Injury Services programs is solicited from other management teams in the agency as well as from community partners and stakeholders. Reports summarizing the numbers served and service outcomes are shared monthly with WWRC's Director and the Director of the Medical Division. As a further part of the oversight process, the **Medical Division's Compliance Program** is involved in audits of individual case records that review admissions procedures, service provider documentation, medical coding, and billing practices; educates staff on compliance issues; and provides quarterly reports to the WWRC executive team. In addition, the manager of BIS Department serves as a state agency representative and non-voting, advisory member of the Virginia Brain Injury Council, reporting to it at least quarterly on WWRC programs and activities, and close links are also maintained with the Brain Injury Association of Virginia (BIAV) and the Virginia Alliance of Brain Injury Service Providers. Identification, discussion, and remedial activities based on these sources of feedback parallel those of other DRS programs.

Community Rehabilitation Case Management (CRCM) Services: Responsibility for oversight of **Department of Rehabilitative Services' (DRS) CRCM Services** rests with its program manager and the director of the **Community Based Services Division**. Monitoring processes have remained constant over time. Customer comments are routinely documented, and concerns are forwarded to the appropriate rehabilitation specialist, program manager, or assistant DRS commissioner as needed. Based on these comments, record reviews, and customer satisfaction surveys, areas needing improvement are identified, and policies are updated as indicated. At the time of this assessment, however, improvements to reporting mechanisms and to evaluations of individuals with disabilities, that were identified as needed in state fiscal year (SFY) 2009, have not been completed.

Comprehensive Services Act (CSA): The organizational structure and oversight provisions of the CSA are complex and cannot be covered in full detail in this assessment, but the basics are described below. State-level oversight consists of a two-tiered, multi-agency system. At the highest level, the **CSA State Executive Council (CSA-SEC)** is chaired by the Secretary of Health and Human Resources or his or her designee. Its other members include the Special Advisor to the Governor on Children's Services; representatives of the General Assembly, the Supreme Court of Virginia, a variety of state agencies, and local governments; public and private providers; two parents; and the Chair of the State and Local Advisory Team (SLAT) described below. The CSA-SEC is responsible for:

- Overseeing the interagency cooperation and collaboration necessary to implement CSA at both the state and local level,
- Appointing SLAT members,

- Establishing appropriate policies,
- Overseeing the use of CSA pool funds, and
- Advising the Governor and Cabinet Secretaries on proposed policy and operational changes.

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

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

The **State and Local Advisory Team (SLAT)** mentioned above makes up the second tier of the state CSA system. Its membership includes staff members from relevant state agencies, parent and provider representatives, a judge, a local CSA coordinator, and five regional representatives who serve on local Community Policy and Management Teams (CPMT). SLAT advises the CSA-SEC on policy and operationalizes CSA-SEC decisions.

While municipalities are required by Virginia law to establish their own two-tiered systems involving a **Community Policy and Management Team (CPMT)** and a **Family Assessment and Planning Team (FAPT)**, they are otherwise given considerable flexibility in designing and delivering CSA services that best fit their situations. To ensure that services are appropriate, cost effective, provide the best possible outcomes for at-risk youths and families, and are in compliance with CSA policies and procedures, localities must have a system in place for review of diagnoses, reasons for services, referrals, and other case data as well as program data on service delivery, quality, and costs. Local reviews may also identify technical assistance and training needs and call attention to policy issues requiring attention at the local or state levels.

The *Evaluation of Children's Residential Services Delivered Through the Comprehensive Services Act*, a 2007 **Joint Legislative Audit and Review Commission (JLARC)** research report (<http://jlarc.state.va.us/Reports/Rpt346.pdf>), found that, despite CSA's focus on keeping

children with their families, at least 54 percent of all CSA expenditures in 2006 were for residential services, which on average were four times as expensive as community-based services. The report identified gaps in community services as a significant contributing factor and noted that receipt of services in an inappropriate (residential) program was found to result in adverse outcomes, such as poorer transition to homes and schools and exacerbated emotional or behavioral problems.

OCS has implemented numerous efforts to address the issues and recommendations from the JLARC report. To strengthen CMPTs and FAPTs, the OCS developed and distributed service models for needs assessments, policy guidelines, assessment tools and skills training, planning, and systems coordination, and four regional OCS technical assistance coordinators are also available to provide CMPTs and FAPTs with ongoing training and consultation. OCS has also modified the CSA data set to capture provider-specific information, mandated use of the Child and Adolescent Needs and Strengths (CANS) standardized assessment instrument described earlier, and in state fiscal year (SFY) 2007 began implementation of an Innovative Community Services Grant program to reduce over-reliance on residential programs.

Six of these grant projects involving 16 local governments were funded in SFY 2007 and 2008. Four of the projects, scheduled to last for 15 months, funded transitional care coordinators to work intensively either with designated children in residential placements to transition them back home or with children at great risk of residential placement to keep them in the home. One of these projects also involved contracting to provide “Wraparound 101” training to all case managers, individual case coaching, and consultation with project staff and the CPMT on a regular, ongoing basis. Another locality established a Multi-Dimensional Treatment Foster Care Program, an evidence-based model of intervention and services for older children. The final locality created a “host home” program called “Parents and Children Together,” that allowed families with children at risk to live in foster homes where the foster parents mentor the child’s parents and assist them in moving towards independence and self-sufficiency. By March 2010, this latter grant, located in Hampton, had trained 37 families, three remained in the program, and no children had returned to foster care.

Funding for these innovative grants was not re-appropriated by the General Assembly after the initial grant period due to budget reductions; however, the six projects described above effectively served as pilots for legislative authorization in the 2009 *Appropriations Act of Intensive Care Coordination*, as a new CSA service to be provided by local Community Services Boards (CSBs). Like the transitional care coordinators funded by the innovative grants, Intensive Care Coordinators work to “wrap” services around a family that will either permit a child to return home from a residential placement or avoid placement of a child in a residential program.

CSA data indicates significant changes in outcomes as a result of these and other initiatives. For example, localities’ effective match rate rose steadily prior to state fiscal year (SFY) 2009, when the community-based services match rate incentive described earlier in the access and delivery section of this chapter was implemented. In the two years since then, it has

declined to 33.33 percent. At the same time, total CSA expenditures have also decreased, by four percent in SFY 2009 and five percent in SFY 2010. The SFY 2009 decrease in expenditures was the first since the implementation of CSA and resulted in annual savings of approximately \$36 million. Localities realized approximately \$14 million in savings that year compared to SFY 2008.

The CSA's *State Executive Council Biennial Report* for 2009 lists additional meaningful CSA changes since 2007:

- The number of foster care youth in group home settings decreased by 40 percent,
- The percentage of youth being discharged into permanent families increased by six percent, and
- The percentage of youth served in group settings decreased from 26 to less than 17 percent.

OCS conducts an annual Critical Services Survey of localities regarding available community services, barriers to services, and service gaps. Its survey for SFY 2009, the fourth conducted, found that crisis intervention services remained the most important critical service need statewide, reflecting no change from the previous three years. The survey also reported a continuing need for intensive substance abuse services for youth in the western, central, and northern regions of state. Not surprising in light of the activities and incentives described above, 77 percent of respondents indicated that their localities had developed new community-based services and that the use of congregate care had been correspondingly reduced. By region, the primary service gaps were:

- Northern Region: Intensive Crisis and Stabilization Services,
- Central Region: Transportation,
- Eastern Region: Regular Family Foster Care,
- Piedmont Region: Psychiatric Assessment, and
- Western Region: Intensive Substance Abuse Services.

Independent Living and Related Services: Under both state and federal statutes, responsibility for oversight of services provided by **Centers for Independent Living (CILs)** rests with their executive directors, individual governing boards, and the **Department of Rehabilitation Services (DRS)** through the Independent Living Services office of its **Community Based Services Division**. DRS oversight is accomplished through site visits and monitoring of CIL activities as well as review of quarterly and annual reports, financial audits, and evaluation of the outcomes of CIL services. Outcome measures track achievement of program activities planned by the CILs, local and statewide training for CIL staff and individuals with disabilities, and local efforts related to statewide systems change initiatives. Examples of the latter include increased access to Medicaid Home and Community Based Services (HCBS) Waivers, increased transportation services, expanded housing options, and the number of individuals who have

transitioned from nursing facilities to community residences or who have been able to avoid entering nursing homes due to CIL support.

Since CIL core services are consumer-directed, feedback from individuals with disabilities receiving services is a crucial part of service implementation and evaluation, and all CILS collect this feedback through a variety of mechanisms. Many have a consumer advisory committee that designs, distributes, and collects responses to a consumer satisfaction survey in a process independent of the CIL staff. Results of these surveys are submitted to their respective executive directors and boards with recommendations for service improvements, changes, or additions.

The **Department for the Blind and Vision Impaired's (DBVI) Rehabilitation Teaching/Independent Living Program** is overseen by a director, assisted by six regional managers who supervise and evaluate the performance of the rehabilitation teachers who deliver RT/IL services. The RT/IL Program's director and regional managers also review case records and accompany the rehabilitation teachers in the field to monitor their effectiveness. Quality assurance procedures for **DBVI Older Blind Grant Program, DeafBlind Services, and Low Vision Services** are similar; however, the program director for Low Vision Services has the additional responsibility for hiring, training, and monitoring the contracted examiners who provided direct services for the program's clients. Periodic performance evaluations of these examiners are reviewed by the Low Vision Services program's director and regional office staff, and if examiners are found to be noncompliant with DBVI policies and practices, their contracts may be cancelled.

The DBVI central office also conducts annual case reviews for each of the regional offices and solicits feedback on services from DVBI's clients and other stakeholders through periodic customer satisfaction surveys and other appropriate means. When problems are detected, corrective actions may result in additional staff training, casework corrections, or other personnel actions. The program directors may modify their policy manuals or arrange for general training to increase the effectiveness of a program. As a recipient of funding from the federal **Rehabilitation Services Administration (RSA)**, DBVI is further required to submit an annual report to that agency, and if RSA finds it to be noncompliant, DBVI must submit a corrective plan indicating the actions to be taken and their projected completion dates.

The DVBI 2008-2010 *Agency Strategic Plan* identified the large size of RT/IL staff caseloads and territories as having a negative impact on the frequency of training lessons, which in turn negatively impacts client skill acquisition. DBVI continues to investigate strategies to improve service delivery and reduce the administrative burden on staff to free time for direct services for individuals. Many DBVI staff now telework from home or other locations helping them serve clients more efficiently by reducing commuting time to and from the office.

In October 2008, to further improve its efficiency and effectiveness, DBVI implemented the **AWARE Case Management System** in partnership with the Department of Rehabilitative Services (DRS). The AWARE system's online tools have enabled DBVI to integrate case

management documentation across all program areas, resulting in better communications, an expedited service authorization process, and improved service delivery. The system has also improved DBVI's ability to budget funds used for customer services and track how those funds are spent over time.

(Non-Waiver) Intellectual Disability Services: As the state's lead agency for intellectual disability services, the Department of Behavioral Health and Developmental Services (DBHDS) licenses public and private providers of intellectual disability services, supplies them with technical guidance, and oversees protection of human rights. For the five state-operated training centers and the 40 local Community Services Boards (CSBs), DBHDS is responsible for operational and fiscal oversight, budgeting and allocation of state funds, and quality assurance.

The key DBHDS accountability tool is the annual *Community Services Performance Contract*, signed by the DBHDS Commissioner and CSB executive directors, that contains numerous data collection and accountability mechanisms to ensure state and federal regulatory compliance and a quality improvement approach to performance. The *Central Office, State Facility, and CSB Partnership Agreement* incorporated into the contract defines system values, delineates roles for each participant that establish a collaborative operational partnership, and identifies processes for improving the quality of care throughout the DBHDS public service system. Locally, administration of each of the CSBs is further guided by a board of directors consisting of six to 18 members appointed by the local governing bodies within their areas of jurisdiction.

The **DBHDS Office of Community Contracting (OCC)** is primarily responsible for negotiating and monitoring the performance contract and works with other DBHDS offices that conduct and document CSB compliance activities pertaining to specific contract requirements. Onsite reviews of CSB client records and fiscal documents are an important part of these monitoring activities; however, DBHDS reports that limited staffing makes conducting them a challenge. When such reviews do occur and compliance issues or deficiencies are found, DBHDS attempts to resolve them initially through informal, then formal, mechanisms that include discussion, negotiation, correspondence, or corrective action plans. If these efforts are not successful, the performance contract allows for other means of resolution that, as a rare and last resort, can include withdrawal of state funding from the applicable service or program.

The **DBHDS Office of Licensing (OL)** is responsible for overseeing application of DBHDS licensure standards, policies, and procedures for the hundreds of providers of treatment, training, and habilitation services for individuals with mental illness, intellectual disability, or substance abuse disorders statewide that must adhere to state regulations. These include providers of day support, in-home residential, or crisis stabilization services under the Medicaid Home and Community Based Services (HCBS) Individual and Family Developmental Disability (DD) Waiver. Licensing staff investigate complaints against providers, which may operate multiple programs or services, and are required to make at least one unannounced inspection of each provider, each year. Staff of the licensing office also train new providers,

supply ongoing technical assistance, and have responsibility for prior authorization of services and supports.

The table below, covering selected state fiscal years (SFY) between 2005 and 2010 and the total change for that period, shows the rate of growth for the work of the licensing office. While the number of providers, services, and service locations has grown significantly, the number of licensing staff positions has remained constant at 15, resulting in substantially higher workloads. To partially address this issue, extensive guidance materials from the licensing office are now available online. The office has also produced training materials in electronic formats for purchase by new providers.

NUMBER OF DBHDS LICENSED PROVIDERS, SERVICES, AND LOCATIONS

State Fiscal Year	2005	2006	2007	2010	Change	Percent
Providers	457	481	529	697	+240	+52.5%
Services	1,084	1,175	1,257	1,662	+578	+53.3%
Locations	2,684	2,764	2,970	5,037	+2,353	+87.7%

Sources: Department of Behavioral Health and Developmental Services (DBHDS), Office of Licensing *Annual Reports* for SFYs 2006, 2007, 2008, and 2010.

The **DBHDS Office of Human Rights (OHR)** is responsible for protecting the legal and human rights of individuals receiving services in state facilities and the community-based programs operated, licensed, or funded by DBHDS (*Code of Virginia, 37.2-400*), with the exception of those operated by the Department of Corrections. In doing so, the human rights office monitors compliance with relevant regulations, promotes the basic precepts of human dignity, advocates for the rights of persons with disabilities, manages the DBHDS human rights dispute resolution process, and supports the work of 80 **Local Human Rights Committees** across the state.

In SFY 2007, the DBHDS Office of Human Rights had 23.5 staff positions for human rights advocates, but as a result of budget cuts and lost positions, that number declined to 19 in SFY 2009 and 18 in SFY 2011, despite the substantial increase in the number of providers, services, and locations to be monitored shown in the table above. In its 2009 annual report (www.dbhds.virginia.gov/documents/reports/OHR-SHRC2009AnnualReport.pdf), the **State Human Rights Committee** expressed deep concern about the negative impact of these cuts in staffing, stating that:

“The loss of these positions impacts every region of the state. At risk is the availability of OHR staff to promote provider compliance with the regulations through consultation and guidance and site visits; respond to human rights complaints; investigate allegations of abuse and neglect; and provide training to consumers, providers and professionals.”

The General Assembly created the **Office of the Inspector General for Behavioral Health and Developmental Services (OIG)** in 2000 to “inspect, monitor, and review the quality

of services provided” by state facilities and public or private entities or organizations that provide community services for persons with intellectual disabilities, mental illness, or substance abuse disorders (*Code of Virginia*, 37.2-423). The Inspector General who heads this office is appointed by the Governor, subject to confirmation by the legislature, for a four-year term that is not coincident with the Governor’s term, and is required to keep the Governor, General Assembly, and Joint Commission on Health Care fully informed of significant problems or deficiencies within the service system and to make recommendations for corrective actions.

Initially, OIG inspections focused on services at state mental health facilities and the state-operated training centers that provide services for individuals with intellectual disabilities, but in 2005, they were expanded to include investigations of community services. This extension of the OIG’s oversight responsibilities specifically included services funded through the Medicaid Home and Community Based Services (HCBS) Individual and Family Developmental Disability (DD) Waiver and Brain Injury Waiver, residential services for persons with brain injury, and individual providers, with the exception of certain practitioners such as those licensed through the board of the Department of Health Professions (DHP). As a part of this legislative change, the OIG now routinely monitors serious incident reports as well as citizen reports of abuse, neglect, or inadequate care by these providers and is authorized to make announced and unannounced inspections of providers to prevent problems or deficiencies and improve service effectiveness.

In addition to investigations and monitoring activities described above, the OIG responds to complaints and requests for information or referral from service recipients, employees of service providers and other citizens on a variety of issues. Its semi-annual reports note 41 such responses between April 1 and September 30, 2009; 23 between October 1, 2009 and March 31, 2010, and 20 between April 1 and September 30, 2010. Information about the OIG’s onsite inspections of the state-operated training centers is summarized in the Institutional Services chapter of this assessment.

With the exception of some OIG investigations that remain unpublished as Governor’s Confidential Working Papers because of executive privilege or the privacy rights of individuals served or their caregivers, the OIG’s website (www.oig.virginia.gov/Reports.htm) provides public access to reports summarizing its investigative findings and recommendations. From state fiscal years (SFYs) 2008 through 2010, OIG staff completed several studies of community services licensed by Department of Behavioral Health and Developmental Services (DBHD) that are briefly described below:

- **OIG Report #149-08, *Review of CSB Children and Adolescent Services*** (issued September 19, 2008): The OIG conducted an extensive survey in 2007 of all Community Services Boards (CSBs) to identify the services being provided, the structure of those services, staffing levels and types, budgets, and factors helping or hindering development of services for youth. Phase 2 of this study, in March and April of 2008, was based on site visits to 34 CSBs. Extensive case record reviews were conducted, and interviews were held with over 1,000 CSB direct service staff and supervisors as well as 175 family

members or guardians. The OIG found wide variability among communities in service availability and that CSBs with the most extensive services for youth provided them by accessing Medicaid resources. The study further found that access to CSB services for youth and families who were uninsured was “extremely limited” statewide.

- **OIG Report # 183-09, *Review of Residential Crisis Stabilization Units Operated or Contracted by Community Services Boards*** (issued February 9, 2010): The OIG conducted onsite reviews of 14 residential crisis stabilization units (CSUs) for adults that were either operated by or contracted by the CSBs to assess their effectiveness in helping individuals avoid hospitalization. OIG staff, along with trained peer inspectors, reviewed clinical records and interviewed direct care staff, supervisors, current and former clients, and other stakeholders. The review found that DBHDS did not clearly establish expectations for program criteria, mission, target populations, or data requirements and that few CSUs accepted individuals who met temporary detention order (TDO) or involuntary commitment criteria.
- **OIG Report #195-10, *Unannounced Inspection at The Pines (Crawford Campus), Portsmouth, Virginia*** (issued October 13, 2010): The Pines, a secured residential treatment facility, serves youth under age 22 who have a diagnosis of mental illness or intellectual disability and a history of assaultive or self-injurious behaviors. About 22 percent of its residents are from Virginia, and most either transferred from correctional facilities or were placed at The Pines by public agencies. The Pines has a history of noncompliance with state licensure requirements and had an extensive Corrective Action Plan in effect. Upon request by the legislative Commission on Youth, the OIG reviewed documentation from the DBHDS Office of Licensing (OL), conducted interviews with OL staff and Pines staff, reviewed Pines documentation, and conducted a site visit. The OIG did not find any current evidence of abuse, neglect, or inadequate care that warranted a formal investigation; however, the OIG emphasized that effective risk management and ongoing quality improvement initiatives were essential to sustain improvements.

Additional investigative and monitoring activities by the OIG are summarized in its semi-annual reports, which are also posted to its website. The activities described briefly below are covered in more detail in those reports.

Following the OIG’s 2007 *Review of Community Services Board Intellectual Disability Case Management Services for Adults*, the Department of Behavioral Health and Developmental Services (DBHDS) informed the OIG that it planned to establish a workgroup to address specific OIG findings and recommendations. The OIG’s October 2010 semi-annual report noted, however, that DBHDS informed the OIG in 2009 that the workgroup had not “...been effectively established so consequently a number of recommendations made by the OIG were never addressed.” Subsequently, in late 2010, DBHDS implemented a taskforce to examine the issues and improve case management services, and the OIG is monitoring this taskforce’s efforts.

The OIG is also monitoring progress by DBHDS to implement the goals and objectives recommended as priorities by the workgroups that produced the *Creating Opportunities* plan described in the introduction to this chapter. A recent, 2010 OIG semi-annual report noted that “development of a ‘model’ service planning system and format that is person-centered... and meets all regulatory requirements” was a recommendation that had still not been addressed. DBHDS has, nevertheless, taken steps in this direction. As a part of the statewide Systems Transformation Grant initiative, also described in the introduction to this chapter, DBHDS has begun a person-centered thinking (PCT) training initiative to improve intellectual disability services provided both at its state-operated training centers and by CSBs. Since 2008, training in the person-centered Individual Support Planning process for the Medicaid Home and Community Based Services (HCBS) Intellectual Disability (ID) Waiver has been conducted for 3,582 staff from CSBs and other public and private nonprofit or for-profit provider agencies, and by the end of state fiscal year (SFY), Virginia will have qualified 18 PCT trainers and three PCT mentors who, in turn, can instruct and qualify additional PCT trainers.

To address another ongoing concern identified by the OIG, DBHDS has collaborated with the Virginia Association of Community Services Boards (VACSB) and the Intellectual Disability Council to identify service gaps for persons who have intellectual disabilities and either a concurrent diagnosis of mental illness or exhibit challenging behaviors and develop a plan to address those gaps. In October 2010, the VACSB released a report responding to this request based on historical data and services available in each of the five CSB regions. The report recommended the establishment of crisis response teams (CRT) and crisis stabilization units (CSU) in each of the five CSB regions. This initiative, estimated to cost \$3,649,860 in state general funds augmented by Medicaid and other insurance, called for:

- Adoption of a statewide service model centered on implementation of CSUs and mobile CRTs in each CSB region,
- Allowing funding of mental health crisis intervention and stabilization services under the Medicaid State Plan for individuals with intellectual disabilities in crisis who do not have a Medicaid Home and Community Based Services (HCBS) Waiver, and
- Creation of an evaluation process to assess effectiveness upon funding and implementation of the model.

Interpreter Services and Related Programs for the Deaf and Hard-of-Hearing: The Virginia Department for the Deaf and Hard of Hearing’s (DDHH) Interpreter Services Program and related Virginia Quality Assurance Screening (VQAS) Program as well as its Outreach Program are overseen by program managers and the agency’s director. As a part of this oversight, program statistics and customer feedback are reviewed routinely on an ongoing, informal basis.

The VQAS diagnostic and proficiency instrument is used to assess the knowledge, skills, and abilities of interpreters and other professionals who facilitate communications for individuals with hearing or speech impairments. Regularly prepared Rater Report Cards ensure consistency

and effectiveness, annual training is provided, and if an individual's performance falls outside of expected standards, retraining is provided. If a complaint is received about a nationally certified interpreter assigned by DDHH, the agency recommends that the complainant file a formal complaint with the certifying body, usually the Registry of Interpreters for the Deaf, Inc. If the complaint involves an interpreter qualified by the VQAS Program, the interpreter must participate in a counseling session to review Interpreter Services Program's code of ethics and other contract requirements. Depending on the outcome of the formal complaint, provisions of that contract allow for its termination by DDHH.

Omnibus Budget Reconciliation Act (OBRA) Services: The **Virginia Department of Rehabilitative Services' (DRS)** is responsible for overseeing that providers of OBRA services for individuals with "related conditions," such as a developmental disability other than an intellectual disability, comply with federal regulations. DRS also monitors performance measures related to OBRA administration under a contractual agreement with the **Department of Behavioral Health and Developmental Services (DBHDS)** and consults with its DBHDS liaison on an ongoing basis. Customer comments are routinely documented and concerns are forwarded to the appropriate rehabilitation specialist, program coordinator, and division director as needed. State agencies participating in the OBRA program report improved overall consumer satisfaction due to programmatic changes and revisions, including more access to rehabilitation engineering and specialized services.

(Non-Waiver) Personal Assistance (PAS) Services: The **State-Funded PAS and PAS for Individuals with Brain Injury (PAS/BI)** are overseen by a program manager and the director of the **Department of Rehabilitative Services' (DRS) Community Based Services Division**. A PAS Advisory Committee comprised of individuals with disabilities, representatives from Centers for Independent Living (CILs), and agency representatives meets quarterly to review the programs and make recommendations for improvements. Feedback is also obtained through consumer satisfaction surveys and other contacts with individuals with disabilities, their families and personal assistants, and the CILs. Internal record reviews and program audits by DRS identify additional areas for improvement, such as recent updates to PAS program policies, the *Consumer Personal Assistance Services Handbook*, and various program forms.

Services for the Elderly Population: As noted earlier, the **Virginia Department for the Aging (VDA)** has been legally designated as the state's "unit on aging" by the federal Administration on Aging and is responsible for oversight of all Virginia programs funded through the federal *Older Americans Act*. It is also responsible for oversight of programs funded through state appropriations and for periodically evaluating the social, physical, and economic needs of older Virginians to determine the extent to which public and private programs are meeting those needs. In addition to planning, coordinating, funding, and evaluating all publicly funded programs for older Virginians, VDA provides staff support for three state advisory boards whose members are appointed by the Governor and General Assembly: the Commonwealth Council on Aging, the Alzheimer's Disease and Related Disorders Commission, and the Virginia Public Guardian and Conservator Advisory Board.

VDA serves as an advisor to the **Area Agencies on Aging (AAAs)** and other contractors that implement services for the elderly population and ensures that those problems meet quality standards. Those service standards are posted to the VDA website and cover recordkeeping, appeals processes, federal and state laws, medication management, use of the Uniform Assessment Instrument (UAI), and other program-specific matters. VDA conducts fiscal and program reviews of programs the AAAs and its contractors and provides onsite technical assistance when needed. When deficiencies are noted, contractors may be required to prepare and implement corrective action plans.

The Public Guardian and Conservator Advisory Board consists of 15 members appointed by the Governor to represent specific organizations or constituencies (*Code of Virginia, 2.2-2411*), advises the VDA Commissioner, and assists VDA staff in the coordination, management, and oversight of **Virginia Public Guardianship Program**. During state fiscal years (SFYs) 2010 and 2011, VDA has been conducting an extensive monitoring review of all local public guardianship programs, reviewing at least 80 percent of client records at each local program. The data collected will be used to establish a performance baseline for future monitoring to ensure compliance with state law and Circuit Court orders. In subsequent years, VDA will annually review a randomly selected sample of at least 25 percent of client records at each program. According to VDA, the quality of local guardianship programs is good, but their scope is currently limited by funding that is inadequate to serve all those needing guardians or conservators. With the number of Virginians ages 65 and older anticipated to rise dramatically in the future, VDA is concerned that the need for public guardianship and other services for this population will only increase.

VDA also has statutory responsibility (*Code of Virginia, 2.2-704*) for receiving, investigating, and resolving complaints made by or on behalf of older Virginians regarding long-term care services provided by state agencies, AAAs, or any other public or private nonprofit or for-profit entities. To do so, it contracts with the Virginia Association of Area Agencies on Aging (VAAAA) to operate the **Long-Term Care Ombudsman Program** and 21 AAAs that provide local ombudsman services. This program works in collaboration with regulatory agencies and programs such as the adult protective services units of local social services departments to foster a non-adversarial process “empowering persons to resolve complaints themselves when appropriate.” To ensure coordinated statewide access, VDA operates a toll-free hotline for information and referrals and requires program staff members to complete a certification curriculum. During state fiscal year (SFY) 2009 the program served 1,879 adults with disabilities and elderly individuals with and without disabilities, an increase of 16.4 percent (265 persons) over SFY 2007. As above, VDA is concerned about this program’s ability to meet growing service needs with limited funding.

Basic oversight practices for the **Department for the Blind and Vision Impaired’s (DBVI) Older Blind Grant Program** are similar to and intertwined with oversight for DBVI’s other programs as explained above under independent living and related services. In addition to these practices, DBVI contracts with Mississippi State University to conduct an annual program

performance evaluation that includes a customer satisfaction survey of a random sample of all individuals who have received services and an onsite visit to observe rehabilitation teachers who work with Older Blind Grant customers.

State regulations (12 VAC 30-120-62) assign primary responsibility for oversight of the **Program of All-Inclusive Care for the Elderly (PACE)** to the **Virginia Department of Medical Assistance Services (DMAS)**. This includes determination of whether to extend PACE coverage to another area of the state, the schedule for doing so, and implementation of the **Request for Application (RFA)** process (12 VAC 30-120-1060). When an entity is selected in response to an RFA, DMAS conducts a feasibility study to determine whether that entity has the ability and resources necessary to effectively operate a PACE program, and DMAS can only contract with those providers who receive a positive determination. Each PACE provider must meet all conditions of participation required by federal Centers for Medicare and Medicaid (CMS) regulations (42 CFR, Part 460) and relevant state statutes (*Code of Virginia*, 32.1-330.2 and 330.3), as well as DMAS regulations, policies, and procedures. Prior to implementation, DMAS conducts an onsite **State Readiness Review** and, as noted earlier, provides training to all preadmission screeners in localities covered by the new PACE program.

Following implementation, DMAS conducts quarterly **Quality Management Reviews** of each PACE program, and in collaboration with DMAS, CMS also conducts an onsite review and evaluation of each PACE program. All reviews include a thorough examination of all PACE processes and procedures, care plans, and participants' medical records to ensure that the health, safety, and welfare of all PACE participants are protected and that each program is in compliance with both federal and state regulations. DMAS also conducts participant and family satisfaction surveys for each PACE program to gather information about enrollment procedures, information sharing, participant care, and other program features. If a noncompliance by a provider is significant enough to warrant such action, DMAS can retract Medicaid payments, terminate the provider agreement, or do both.

G. Community Supports Sources Referenced in This Chapter

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

Websites:

Brain Injury Association of Virginia (BIAV):

www.biav.net

NewWell Fund:

www.newwellfund.org

Office of the Attorney General of Virginia:

www.oag.state.va.us

Office of the Inspector General (OIG) for Behavioral Health and Developmental Services:

www.oig.virginia.gov

OIG Reports:

www.oig.virginia.gov/Reports.htm

Office of the Secretary of Health and Human Services (HHR) of Virginia:

www.hhr.virginia.gov

Systems Transformation Initiatives:

www.hhr.virginia.gov/Initiatives/SystemsTransformation

SeniorNavigator:

www.seniornavigator.org/ccss_overview.php

Statewide Independent Living Council (SILC):

www.vasilc.org/statewideindependentlivingcouncil.htm

U.S. Administration on Aging (AOA):

www.aoa.gov

Community Living Program:

www.aoa.gov/AoARoot/AoA_Programs/HCLTC/NHD/index.aspx

Virginia Association of Area Agencies on Aging (VAAAA):

<http://vaaaa.org>

Virginia Association of Community Services Boards:

www.vacsb.org

Virginia Auditor of Public Accounts (APA):

www.apa.virginia.gov

Audit Reports:

www.apa.virginia.gov/reports.cfm

Virginia Department for the Aging (VDA):

www.vda.virginia.gov

Area Agencies on Aging:

www.vda.virginia.gov/aaalist.asp

Community Living Program:

www.vda.virginia.gov/communityliving.asp

No Wrong Door Initiative:

www.vda.virginia.gov/nowrongdoor.asp

Public Guardianship and Conservatorship Program:

www.vda.virginia.gov/vapublicguardpgm.asp

Virginia Department for the Blind and Vision Impaired (DBVI):

www.vdbvi.org

Rehabilitation Teaching/Independent Living:

www.vdbvi.org/RTILS.htm

Older Blind Grant Program Annual Reports:

<http://www.vdbvi.org/OBGPAR.htm>

Virginia Department for the Deaf and Hard-of-Hearing (DDHH):

www.vddhh.org

Interpreter Services:

www.vddhh.virginia.gov/IpAbout.htm

Technology Services:

www.vddhh.virginia.gov/TechIntro.htm

Virginia Relay:

www.varelay.org

Virginia Department of Behavioral Health and Developmental Services (DBHDS):

www.dbhds.virginia.gov

Office of Community Contracting:

www.dbhds.virginia.gov/OCC-default.htm

Office of Developmental Services:

www.dbhds.virginia.gov/ODS-default.htm

Person Centered Practices:

www.dbhds.virginia.gov/ODS-PersonCenteredPractices.htm

Office of Human Rights:

www.dbhds.virginia.gov/OHR-default.htm

Office of Licensing:

www.dbhds.virginia.gov/OL-default.htm

Office of Planning & Development:

www.dbhds.virginia.gov/OPD-default.htm

Omnibus Budget and Reconciliation Act (OBRA):

www.dbhds.virginia.gov/omh-obra.htm

Virginia Department of Health (VDH):

www.vdh.virginia.gov

Division of Long Term Care:

www.vdh.virginia.gov/OLC/LongTermCare

Office of Licensure and Certification:

www.vdh.virginia.gov/OLC/index.htm

Virginia Department of Medical Assistance (DMAS):

www.dmas.virginia.gov

Children's Mental Health Demonstration Waiver:

http://dmasva.dmas.virginia.gov/Content_atchs/mch/mch-cmh1.pdf

Division of Long Term Care:

http://dmasva.dmas.virginia.gov/Content_pgs/ltc-home.aspx

Program of All-Inclusive Care for the Elderly (PACE):

http://dmasva.dmas.virginia.gov/Content_pgs/ltc-pace.aspx

Virginia Department of Planning and Budget (DPB):

www.dpb.virginia.gov

Virginia Department of Rehabilitative Services (DRS):

www.vadrs.org

Brain Injury Services Coordination (BISC):

www.drs.virginia.gov/cbs/biscis.htm

Virginia Brain Injury Council:

www.drs.virginia.gov/vbic.asp

Community Based Services:

www.drs.virginia.gov/community.htm

Community Rehabilitation Case Management (CRCM):

www.drs.virginia.gov/cbs/lterm.htm

Personal Assistance Services:

www.drs.virginia.gov/cbs/pas.htm

Virginia Assistive Technology System (VATS):

www.vats.org

Virginia Reuse Network:

www.vats.org/atrecycling.htm

Woodrow Wilson Rehabilitation Center:

www.wwrc.virginia.gov

Brain Injury Services:

www.wwrc.virginia.gov/braininjuryservices.htm

Spinal Cord Injury Program:

www.wwrc.virginia.gov/spinalcordinjury.htm

Virginia Office of Comprehensive Services (OCS) for At-Risk Youth & Families:

www.csa.state.va.us/index.cfm

Child and Adolescent Needs and Strengths (CANS) Assessment:

www.csa.state.va.us/html/CANS/cans.cfm

CSA Statewide Statistics and Reports:

www.csa.virginia.gov/publicstats/index.cfm

Systems of Care:

www.csa.state.va.us/html/systems_of_care/systems_of_care.cfm

Virginia Easy Access:

www.easyaccess.virginia.gov

Virginia General Assembly:

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

2011 State Budget:

<http://leg2.state.va.us/MoneyWeb.NSF/sb2011>

Code of Virginia:

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

House Appropriations Committee:

<http://hac.state.va.us/welcome.htm>

Joint Legislative Audit and Review Commission (JLARC):

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

Study Reports and Briefings:

http://jlarc.state.va.us/pubs_rec.htm

Senate Finance Committee:

<http://sfc.virginia.gov/index.shtml>

Virginia Administrative Code:

<http://leg1.state.va.us/cgi-bin/legp504.exe?000+men+SRR>

Virginia Office for Protection and Advocacy (VOPA):

www.vopa.state.va.us

Virginia Performs:

www.vaperforms.virginia.gov

Health and Human Resources Secretariat:

www.vaperforms.virginia.gov/agencylevel/src/secretariat.cfm?sec=Health

State agency Strategic Plans:

www.vaperforms.virginia.gov/agencylevel/index.cfm

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