

IV. Health Care

A. Introduction to Health Care Services and Resources

Virginians, with or without disabilities, who have health insurance (private or Medicaid or Medicare) can receive direct health services from a variety of providers and practitioners, both private and not-for-profit. Regional differences do exist in the availability and accessibility of providers. Notable “safety net” resources for health and dental care include Federally Qualified Community Health Centers, which are nonprofit organizations; and local Free Clinics, which are staffed by volunteers and primarily serve adults.

This chapter focuses on the direct health care services administered, funded, or operated by two state agencies that serve Virginians who are under-insured or have no insurance:

- **The Virginia Department of Health (VDH)**, as authorized by the Code of Virginia (§ 32.1), provides services that are open to the general population rather than specifically targeted to those with disabilities.
- **The Department of Behavioral Health and Developmental Services (DBHDS) - Regional Community Support Centers (RCSCs)**. Through state fiscal year (SFY) 2014, the RCSCs will continue to operate through state Training Centers to fill regional service gaps for individuals with intellectual and other related developmental disabilities.

In August 2008, the **US Department of Justice (DOJ)** initiated an investigation of the Central Virginia Training Center (CVTC) pursuant to the Civil Rights of Institutionalized Persons Act (CRIPA). In April 2010, the DOJ notified the Commonwealth that it was expanding its investigation to focus on Virginia’s compliance with the Americans with Disabilities Act (ADA) and the US Supreme Court’s 2009 *Olmstead* ruling. The *Olmstead* decision requires that individuals be served in the **most integrated settings appropriate** to meet their needs consistent with their choice. In February of 2011, the DOJ submitted a summary of findings to Virginia, concluding that the Commonwealth failed to provide services to individuals with intellectual and developmental disabilities in the most integrated settings appropriate to their needs.

As part of the DBHDS implementation plan for the Department of Justice (DOJ) **Settlement Agreement**, the RCSCs are being transformed into community-based services that will be known as the **Developmental Disability Health Support Network**. Because this transition has not been completed and the information provided here is historical in nature, this chapter refers to these as RCSCs for ease of reference. After an overview of current health care issues and needs and of the Commonwealth’s legislative efforts to address them, the remainder of this chapter provides details on services provided through the VDH and RCSCs.

Over the past century, advances in sanitation, food safety, disease prevention, and medical treatment have significantly improved the health and well-being of all Americans. As a result, life spans have increased, most notably for individuals with a developmental or other disability. Having a disability, whether congenital or acquired, does not mean an individual does not have good health. A growing body of medical research, however, indicates that persistent health disparities exist in service access and outcomes for various populations, especially minorities and individuals with disabilities who historically have experienced discrimination, segregation, or exclusion. The US Department of Health and Human Services defines a “**health disparity**” as

a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage.

Healthy People 2020, a national initiative of the Department, notes that varieties of interrelated factors (or determinants) affect personal health and wellness, and thus contribute to health disparities. These determinants fall into the following broad categories:

- biology and genetics;
- individual behaviors (smoking, lack of exercise, overeating, alcohol/drug abuse);
- social (race, ethnicity, disability, economic status);
- environment (home and neighborhood);
- health services (quality, availability, accessibility);
- geography (rural vs. urban); and
- local and state policies.

Additionally, Healthy People 2020 reports that local and state policies can directly affect individuals’ access to and the availability of (1) types of services, (2) affordable, reliable transportation, and (3) affordable health insurance. More information on the initiative is available at <http://www.healthypeople.gov/2020/about>.

According to the US Surgeon General and Healthy People 2020, individuals with developmental or other disabilities often face the additional risks of **secondary health conditions** related to their disability. For example, individuals with mobility impairment who rely on wheelchairs have a greater risk of pressure sores, lost muscle tone and obesity. Those with spina bifida can have greater risk for gait instability and falls. Certain developmental disabilities tend to be associated with a predisposition to respiratory infections or other pulmonary problems, or to cardiovascular diseases. Overall, research indicates that, as a group individuals with physical and/or intellectual disabilities are in worse health than the general population.

Systems barriers are recognized as a key factor negatively impacting wellness and health for individuals with disabilities. These barriers may be encountered as:

- inaccessible medical facilities and equipment (such as lack of height adjustable examination tables, lifts, or adaptive mammography equipment);
- inaccessible gyms and recreational exercise facilities;
- inadequate numbers of trained staff; and
- limitations or lack of insurance coverage for assistive technology, equipment, medications, or dental care.

Many of these barriers persist, despite the expectations sets forth by the Americans with Disabilities Act (ADA). A 2011 report by the University of New Hampshire Institute on Disability points out:

Many of the health challenges experienced by people with disabilities are preventable given access to medical care, attention to health promotion and disease promotion, and improved social circumstances.

Tracking of health care to citizens, with and without disabilities, has increased over the past decade. Nationally, in addition to the Healthy People 2020 project, the **US Centers for Disease Control (CDC)** monitor the prevalence of various developmental and other disabilities as well as major chronic health conditions, and access to health care. The CDC posts national and state findings from the **Behavioral Risk Factor Surveillance System (BRFSS)**, which monitors numerous health indicators for adults with and without disabilities.

Begun on a national level in 1993, the BRFSS is a phone survey of a random sample of adults (ages 18 and older) who are not residing in any type of institution. The survey, which is conducted over a two-year period by each state, collects self-reports of health-related behaviors, chronic health conditions, and the use of preventive services. While the BRFSS has a core questionnaire, each state can administer optional question modules. To improve representativeness and reduce selection bias, the CDC uses various statistical methods to weigh the survey data against numerous demographic variables. As a result, the published reports have at least a four-year time lag from the time of collection.

Limitations in generalizing the findings for methodological reasons must be noted. The BRFSS excludes all adults residing in any institution (health care and correctional) and anyone who does not have a phone. The survey categorizes respondents very broadly as “with disability” or “no disability” and “don’t know” or “refused.” The latter two groups were not included in the analysis. The self-report of a disability was broadly defined using one question, “Are you limited in any way in any activities because of physical, mental, or emotional problems?” Both local and state health departments use BRFSS data to monitor progress on agency objectives, implement health promotion and disease prevention activities, and to monitor health trends. More information on the survey is available at <http://www.cdc.gov/brfss/>.

The most recent BRFSS data available on Virginians with disabilities is found in the report, *Health Status of Virginians with Disabilities, 2007–09*. The survey was conducted by the Division of Chronic Disease Prevention and Control at the Virginia Department of Health (VDH) with staff at the Partnership for People with Disabilities (PPD) at Virginia Commonwealth University (VCU) providing data analysis. Across numerous indicators, poor health status or more severe conditions were most frequently reported by individuals who had annual incomes of less than \$35,000 or were over age 65. The survey also found that:

- Individuals with a disability reported their health as “fair” or “poor” (43.5 percent) six times more frequently than those with “no disability” (7.3 percent)—a statistically significant difference.
- Compared to those with no disability (10.0 percent), individuals with a disability were twice as likely (20.6 percent) to report not seeing a doctor when needed because of cost in the past year—a statistically significant difference.
- Lack of dental insurance was sizeable for both populations with 42.8 percent of individuals with a disability and 26.8 percent of those with no disability lacking dental insurance.
- Individuals with a disability were more likely to report having a diagnosis of arthritis, asthma, high blood pressure, and heart disease (e.g., angina, heart attack, stroke, or coronary heart disease).
- Individuals with a disability had higher rates of receiving a flu vaccine (51.4 percent) and the pneumonia vaccine (38.5 percent) than those with no disability (39.0 percent and 21.4 percent, respectively).

The relationship of good **oral health** to overall physical well-being has been well documented. The US Surgeon General issued a major report on oral health in 2000, followed by a national “Call to Action” plan in 2003. The 2000 report points out the importance of good dental hygiene for one’s general health. For example, the oral membrane (which covers tissue in the mouth) and the salivary glands are key parts of the body’s immune system. Severe tooth decay leads to intense toothaches. If a tissue abscess develops, the jawbone can be damaged and infection can spread into the bloodstream, resulting in systemic infection. Pregnant women with tooth decay are at more risk for premature birth and for having a low birth weight child. Higher risk of oral problems also is associated with having diabetes (Type I or II), having a weakened immune system, being poor, or smoking regularly.

The US Centers for Disease Control (CDC) points out that millions of work hours are lost annually due to oral health problems by employed adults. CDC studies indicate that a little over 30 percent of adults reported not having a dental appointment in the past 12 months. The CDC notes that

for every adult 19 years or older without medical insurance, there are 3 without dental insurance.

More CDC information on oral health is available at
http://www.cdc.gov/OralHealth/children_adults/adults.htm.

Over the last decade, health reform efforts at both the national and state levels have increased due to many factors. The most significant are as follows:

- Costs for health care and health insurance rose significantly higher than inflation and incomes.
- During the Great Recession and slow recovery, many citizens who lost health insurance with their jobs became eligible for Medicaid, causing higher state expenditures.
- Implementation of the Affordable Care Act (ACA) (H.R. 3590 as amended).

Increased attention has been given to identifying the underlying factors that contribute to high health care costs and effective health care reform strategies to both improve service quality and reduce costs. Reform discussions and planning have begun to include preventative dental care, which often is not covered by either public or private insurers.

In 2010, the Commonwealth began the **Virginia Health Reform Initiative (VHRI)**. The VHRI has been led by the Secretary of Health and Human Resources and conducted by a Governor-appointed Advisory Council comprised of leaders from health care, insurance, legislators, and businesses. Its purpose has been to develop and recommend to the legislature a comprehensive strategy for implementing health care reforms that promote Virginia's economic growth as well as more effective, efficient delivery of high quality health care at lower costs. Six VHRI Advisory Council Taskforces are organized around six health care issues and conducted fact-finding meetings on their respective issues, which are as follows:

1. Medicaid reform (see the **Medicaid** chapter for details),
2. health insurance reform,
3. capacity (workforce),
4. service delivery and payment reform,
5. technology, and
6. purchasers.

The VHRI Purchasers Taskforce addressed business strategies to improve choice, flexibility, quality, and the cost of employee health insurance. Both the VHRI Advisory Council and each Taskforce was charged to:

go beyond federal health reform and identify other innovative health care solutions for Virginia.

Since their formations, each VHRI entity met regularly, obtained public comment and information from a wide array of stakeholders, including employers, insurance companies,

citizens, health care providers, and medical associations, among others. VHRI efforts included research on health care innovations occurring in other states on each taskforce topic.

Pursuant to House Bill 2434, in November 2011, the VHRI Advisory Council released its report on recommended legislative actions to address the Affordable Care Act requirement for states to either create their own Health Benefit Exchange (HBE) or contract with the federal Department of Health and Human Resources to operate one. The VHRI Council recommended that Virginia establish its own exchange, and identified key components and issues for its creation. The recommendation was opposed by then Governor McDonnell. During the 2012 and 2013 legislative sessions, bills were proposed to create a state-operated HBE, but the proposals were not enacted. Similar bills were proposed in the 2014 General Assembly, but at the time of this assessment, no decision had been made. Nevertheless, the research and reports from the VHRI form an important legislative context for future decision-making regarding health services.

Current Governor McAuliffe supports eliminating the coverage gap. Passage of the SFY 2015–16 state budget was delayed due to the controversy of Medicaid expansion with the House and Senate disagreeing over whether the discussion of Medicaid expansion should be part of budget negotiations or considered separately. In mid-June of 2014, the General Assembly passed a budget without Medicaid expansion in order to address an unanticipated significant budget shortfall. A further provision was included that requires full General Assembly approval of Medicaid expansion. The budget will go to the Governor for his review.

Individuals with chronic health conditions too often contend with fragmented services and poor communication between providers. Complications from and acute exacerbations of chronic health conditions often can be prevented with appropriate, timely medical treatment. In turn, appropriate medical care can reduce costs through prevention of hospitalizations and emergency room visits. The 2010 General Assembly, through House Joint Resolution 82, tasked the **Joint Commission on Health Care (JCHC)** to “study the feasibility of developing chronic health care homes in the Commonwealth” and to include identification of service standards, certification standards, and estimated costs of a demonstration program. A chronic health care home (often referred to as “medical home”) is a team-based, person-centered model of care that is led by a personal physician and plans and delivers health care to address the needs of individuals with multiple chronic conditions.

In its 2012 report of findings (House Document #9 available at <http://leg2.state.va.us/dls/h&sdocs.nsf/4d54200d7e28716385256ec1004f3130/7f6815bd7a3826d585257738006fc1a0?OpenDocument>), the Joint Commission on Health Care (JCHC) identified several person-centered models of primary care that demonstrated both improved individual health and reduced health care costs. Key features of these models were (1) leadership by a primary care physician, (2) a team approach, and (3) ongoing, coordinated care. JCHC found that several initiatives were underway in Virginia to promote “health care homes.” Among these is a grant made to the state Department of Medical Assistance Services (DMAS) from the National Academy of State Health Policy to develop and implement policies to

increase access to quality “medical homes” for Medicaid and Children’s Health Insurance Program (CHIP) participants. The JCHC report noted that a number of family medicine physicians statewide had either begun, or were about to begin, implementation of chronic health care homes. The JCHC decided to continue monitoring the progress of these efforts and related health care innovations.

The 2010 legislature additionally charged the JCHC to conduct a study on the volume and costs of hospitals statewide in serving individuals who were financially indigent (“**charity care**”); and to identify incentives to encourage services to that population (House Joint Resolution #27). As of January 2014, the Affordable Care Act requires all individuals to obtain health insurance coverage, which could impact the need for charity care. The final report, published in 2011, found that not-for-profit hospitals provided more charity care as a percentage of revenues than for-profit hospitals. Problematic, however, is that no state standard exists to define the calculation of charity care, resulting in different methods used for calculations by different hospitals. The JCHC, in collaboration with hospitals, will continue to explore a potential standardized definition of hospital charity care and to discuss trends over time.

As the VHRI progressed, legislative concerns about health care costs expanded to the issue of public costs that result from untreated **dental disease**, an issue that also has received national attention over the past decade. In 2011, as a cost-reduction strategy, the **Virginia Department of Health (VDH)** proposed to the administration and legislature that its clinical dental services be restructured to align better with an evolving agency mission of more preventive and population-based programs. The 2012 General Assembly special session enacted a budget requirement (Item 296-F in Chapter 3) that tasked the VDH, in collaboration with the Department of Medical Assistance Services (DMAS), to create a dental advisory committee of community individuals and dental organizations to address that proposal. The legislature requested a report to:

- evaluate “the sustainability and efficiency” of current VDH-operated dental clinics;
- evaluate the feasibility of transitioning VDH dental services to a prevention-only model; and to
- develop a comprehensive oral health plan.

The advisory committee was convened and held several meetings to examine the fiscal, utilization, and client demographic data of current VDH-operated dental clinics statewide as well as distribution of other “safety net” dental providers. The resulting *VDH Oral Health Plan*, submitted in October of 2012, concluded that the current system of VDH dental clinics was not sustainable without a significant influx of state General Funds (GF). In state fiscal year (SFY) 2012, 40 percent of dental clients were indigent and received free services; another 11 percent paid a minimal fee based on a sliding scale; and the remainder was children on Medicaid. State compensation policies additionally made recruitment and retention of qualified dental staff very difficult in some localities. The plan recommended that a “targeted regional approach” be adopted, which would selectively transition some dental clinics to a prevention model based on

analysis of community needs and available dental resources, especially safety net providers. The VDH plan also requested an additional year of General Fund support for existing dental clinics to allow appropriate transition planning.

The VDH plan, which includes communication with and input by local stakeholders, was approved. Over the next year, VDH collaborated with the Virginia Dental Association, the Virginia Oral Health Coalition, and other stakeholders to develop implementation plans. The Stakeholders Advisory Committee reviewed extensive data on local populations, dental resources, and other factors. In October of 2013, the VDH submitted its legislative report, **Dental Transition Plan**. This plan proposes a major restructuring of the VDH-operated dental clinic system. The plan identified district VDH dental programs that would be maintained as being “critical” to their communities: Mount Rogers, Norfolk, and Western Tidewater. Others would be transitioned to a prevention model through an expanded dental hygienist workforce within the VDH Office of Family Health Services. Dental hygienists work under “remote supervision” in local schools (as outlined under Code of Virginia § 54.1-2722).

The VDH deputy commissioner for Community Health Services has provided plan templates for activities to close or modify local dental clinics, including efforts to assure care continuity for current dental clients. However, the plan notes that remaining VDH dental clinics will need significant state funding after SFY 2014 for local VDH dental clinics to maintain current professional standards for staffing and infrastructure.

A related 2012 legislative proposal (Senate Joint Resolution 50) recommended a study of the financial impact and availability of dental services. Although not passed by the legislature, this study was initiated in 2013 by the Joint Commission on Health Care (JCHC). The JCHC study examined (1) the financial impact of untreated dental disease on Medicaid expenditures, (2) uncompensated dental-related care provided through hospital emergency rooms, and (3) both the scope and value of dental services from safety net providers, such as local health clinics and Free Clinics. In November of 2013, the JCHC presented its findings in its *Study on the Cost of Untreated Dental Disease on the Commonwealth*. Based on its findings, the JCHC adopted the following as legislative recommendations:

- The JCHC will propose a budget amendment to expand Medicaid to include full dental services for pregnant women with appropriations of \$3,627,804 each in General Funds and Non-General Funds per year.
- The 2014 JCHC work plan will include a targeted study of the service capacity and educational priorities of dental safety net providers. The study will include an in-depth exploration of proactive strategies to divert individuals from emergency room use to community providers and will address “alternative settings where additional providers (such as registered dental hygienists) can provide access to more individuals.”

Of note is that, based on public comments, the 2014 JCHC dental study will engage a broader array of oral health stakeholders—including the Virginia Dental Hygienists Association

and the VCU School of Dentistry, among others—in examining the long-term actions and resources needed to “... improve education, awareness and pro-activity for changing oral hygiene habits.” A final report will be available in 2015.

The United States continues to have the highest per capita health care costs of any industrialized nation. This reality, along with the many factors discussed herein, will keep the interest-level high for improving the quality and efficiency of health care services for years to come. As noted above, the Commonwealth’s Joint Commission on Health Care will remain engaged in examining ways to improve services and reduce costs.

B. Virginia Department of Health Programs

The Virginia Department of Health (VDH) is the primary state agency focused on public health for residents of the Commonwealth. Its mission is “to promote and protect the health of all Virginians” with a vision of “Healthy People in Healthy Communities.” By state and federal law, the VDH is responsible for 41 “service areas” included in the following broader categories:

- Maternal and child health
- Communicable disease prevention and control
- Environmental health hazards protection
- Drinking water protection
- Medical examiner services
- Emergency preparedness response and recovery
- Vital records and health statistics
- Health assessment, promotion and education
- Quality oversight of health services

To achieve its mission, the VDH provides leadership and expertise to localities in a wide variety of areas, most of which affect all citizens:

- Community Nutrition and the Women, Infants and Children (WIC) nutrition programs
- Maternal and infant health (for reduced Mortality rates and improved pre-natal maternal care)
- Dental services
- Emergency Medical Services and emergency preparedness
- Public health nursing

- Chronic disease prevention (including immunization programs and maintenance of the Virginia Immunization Information System as well as prevention of rabies, HIV/AIDS, tuberculosis, sexually transmitted diseases, and others)
- Health equity (to address disparities in the availability of and access to quality health care for rural and other underserved populations)
- Injury and violence prevention
- Drinking water protection (involving waterworks owners, operators, laboratories, consumers)
- Environmental health (including restaurant inspections, sewage and water services, food safety, lead monitoring, and shellfish sanitation)
- Birth, death and marriage certificates
- Health statistics
- Licensure and certification of nursing facilities, medical facilities and services, and intermediate care facilities for individuals with intellectual disabilities (ICFs/IID)

VDH activities are highly decentralized. Services are provided through a network of 35 local health districts that support 119 individual, municipal health departments. While localities with high population densities have dedicated districts, some health districts, especially in rural areas, cover multiple localities.

Each local health department prioritizes services based on assessments of municipal health needs and conditions. The availability and nature of services at public health clinics across Virginia varies based on local needs, funding, and differing public risk levels for certain health problems. Unless otherwise indicated, the VDH health services listed in this chapter operate through this network, either by directly providing services or by contracting with local service providers. This network collects data on local health care needs and service levels, which is reported to VDH. Only two health districts, Fairfax County and Arlington, manage their own local department and district. The other thirty-three health districts are staffed with state VDH employees.

The full scope of VDH services and activities can be viewed on its website at <http://www.vdh.virginia.gov>. For this *Assessment*, only those VDH programs that provide direct services and are likely to be used by Virginians with disabilities are addressed. Many of the VDH's programs are administered by the **Office of Family Health Services within the Division of Child and Family Health**. Information about all programs and services under this division is available online at <http://www.vdh.state.va.us/ofhs/childandfamily/>. Data on the number of individuals who have disabilities and who received these services is generally not available. Wherever specific access, enrollment, and participation information on a VDH service is available, it is included under the appropriate program. Services provided through VDH programs are described, as much as possible, in order of the target population's age.

1. Eligibility for VDH Services

Generally, all Virginians (with and without disabilities) are eligible for health department services. Eligibility for Virginia Department of Health (VDH) programs typically are based the individual's age, family income, and insurance coverage, as well as whether the individual belongs to a group that is at special risk for a specific health problem now or in the future. However, variation exists based on the purpose of various programs. Prevention and education services often are provided to individuals at no cost. Since local health departments vary in the services offered, not all programs are universally available statewide. Individuals can explore eligibility and program information by contacting their local health department or visiting the VDH website, which includes enables users to find local health services by county. It is at <http://www.vdh.virginia.gov/VDHprograms.htm>.

2. Access to and Delivery of VDH Services

With a few exceptions, the public health programs under VDH primarily provide information on local nonprofit or private health care providers, support citizens in accessing them, or coordinate the delivery of services between them. Access points for specific publicly provided health care assessment, management, and support services targeted specifically at people with disabilities are described below.

3. Available VDH Services

The **Division of Child and Family Health** within the **VDH Office of Family Health Services** administers a number of the programs most relevant to Virginians with disabilities. Within this division are three major units, each of which has multiple programs and services:

7. Child Health,
8. Dental Health, and
9. Reproductive Health.

The broad goals of these programs are to improve both maternal health (perinatal and post-natal) and infant/child health and also to promote wellness and prevent disease. Information about services available under the VDH Division of Child and Family Health is online at <http://www.vdh.state.va.us/ofhs/childandfamily>. The services described here are presented in a rough chronological order that anticipates how a child or family member might use them.

Located within the Child Health Unit are two programs of the **Virginia Genetics and Newborn Screening**: the **Newborn Screening Program** and the **Virginia Early Hearing Detection and Intervention Program (VEHDIP)**. The Virginia Genetics and Newborn Screening unit is responsible for ensuring that newborns are screened for potentially disabling or life-threatening conditions. Through its programs, services, and partners, the unit works with a multi-layered network of local public and private service providers that are linked by particular health conditions or disabilities. Direct services provided through its programs vary considerably as they focus on various, specific genetic conditions. The screening programs are aggressive in

their outreach to the general population as well as to local health care professionals and organizations. Extensive educational materials on a wide variety of genetic and other developmental disorders are made available to parents and primary health physicians.

The **Newborn Screening Program** is a comprehensive system of diagnostic services, medical treatment, and dietary management and treatment. Working in partnership with three regional genetic centers operated by Virginia's medical schools (University of Virginia, Virginia Commonwealth University Health System, and Eastern Virginia Medical School), this program aims to ensure early identification of congenital conditions as well as to link families to appropriate resources for health and disability services. The efforts of this program enable newborns to receive treatments that may improve or prevent more serious health and functional impairments that may occur if intervention is not started soon after birth. Newborn screening also supports optimal child development and promotes the health and wellness of children.

In general, Newborn Screening Program staff work with hospitals, physicians, and families to ensure that physicians and hospitals statewide collect necessary blood samples for testing by the Virginia Department of General Services' Division of Consolidated Laboratories, which are under contract with the VDH. Every newborn in Virginia is tested a few days after birth unless a parent or guardian objects on the grounds that the test conflicts with their religious practices. When screening identifies a serious condition, as required by state law, program staff then assures notification of the child's parents and primary care provider about the abnormal screening results. Newborns diagnosed through the screening program are referred to the Care Connection for Children for follow-up services and supports.

Newborn screening results and follow-up activities are also reported to the **Virginia Congenital Anomalies Reporting and Education System (VaCARES)**. VaCARES, a VDH registry of children under age two who have a birth defect. It collects data on birth defects to evaluate both their prevalence and possible causes as well as to have a mechanism for informing families of children with birth defects and their physicians about available health resources. As required by Code of Virginia § 32.1-69.1, hospitals must report cases of birth defects to VaCARES. Birth defects can be reported and reviewed without prior written consent of the family. VaCARES data are kept strictly confidential, and VDH only uses aggregate data for research to evaluate patterns and causes of birth defects. The VaCARES webpage includes a brochure listing key disability resources for families of an infant with special needs and numerous fact sheets on various types of birth defects and developmental disabilities. It is located at <http://www.vahealth.org/gns/vaCares.htm>.

Newborn Screening Program staff also may assist with referrals to appropriate resources for follow-up through the regional genetic centers and identified specialists. When a child's genetic condition requires metabolic treatments or special foods, families are referred to one of three regional metabolic treatment centers located at Virginia's three medical schools (UVA, VCU-HS, and EVMS). Physicians and nutritionists there help to develop and implement a plan of care for infants whose families are medically indigent. In addition, the program offers a

Food/Supplement Reimbursement Plan to Virginia residents who meet the financial and medical eligibility criteria. This plan provides limited reimbursement for certain necessary low-protein modified foods, formulas, and/or metabolic supplements.

When screening identifies a hearing impairment or loss or the potential for such, the **Virginia Early Hearing Detection and Intervention Program (VEHDIP)** serves as a primary source for referrals for follow-up services. VEHDIP goals are to ensure that:

- all infants are screened for hearing loss by one month of age;
- any diagnosis of hearing loss is made by three months of age; and
- diagnosed infants receive early intervention services by six months of age.

Staff follow-up is conducted on newborns who either have negative results from their hearing screen or do not have a reported screening. They work with the family, the primary care providers, and audiologists to confirm the child's hearing status. VEHDIP staff also provides parents with explanatory information on the importance of early intervention and discuss what to expect in the future as well as available local resources. Parents are directly assisted in arranging follow-up assessments, as indicated; in obtaining communications support (including assistive technology) and educational support; and with referrals to appropriate resources of the **Virginia Department for the Deaf and Hard of Hearing (VDDHH)**.

In collaboration with VDDHH, VEHDIP staff develops policies and procedures, identifies best practices, and recruits additional community providers to address the needs of these children. VEHDIP training and guidance is supplied in localities to ensure that physicians and hospitals: (1) perform required hearing screenings for children in a timely manner, (2) provide all prospective parents with information on auditory screening requirements, and (3) provide the screening results to VaCARES and to parents.

The Virginia Department of Health (VDH) reports that, due to VEHDIP activities, in 2011, 98.2 percent of infants born in Virginia were screened for hearing loss prior to hospital discharge. Upon further diagnostic evaluation, 147 children were identified with a permanent hearing loss, and 49 percent of those children were diagnosed before 3 months of age. Documentation on linkage to services is incomplete and varies widely between years; however, in 2011, 21.8 percent of children with permanent hearing loss were documented as receiving **Part C Early Intervention** services by 6 months of age, and 26 percent of these children also received other early intervention services by 6 months of age.

VDH is currently implementing data system changes to allow for more thorough tracking of Part C early intervention services. While these percentages have declined from a high point reached in 2006, VDH staff believes that the data represent an undercount because information on enrollment in IDEA Part C Early Intervention Services [pursuant to the Individuals with Disabilities Education Improvement Acts (IDEA)] cannot be shared without parental consent. (See the **Early Intervention** chapter of this *Assessment* for more information.)

The **VDH Loving Steps Program**, a Virginia Healthy Start Initiative, employs nurses, dietitians, and community health workers to provide case management services for women and infants who are at risk for poor perinatal outcomes. This initiative targets localities that have high rates of low birth weights, premature deliveries, and infant deaths. Many of these localities also have high rates of poverty or of having little or no health insurance coverage. Loving Steps services currently are provided in Westmoreland County and the cities of Norfolk and Petersburg. Loving Steps strives to reduce infant mortality and reduce significant perinatal health disparities.

Intensive case management and care coordination for the mother and infant is conducted by a multi-disciplinary team (nurses, dietitians, and community health workers). Local case managers arrange screenings for medical, nutritional, social, economic, and environmental risks, identify service gaps, develop a plan of care, and make referrals to other services and resources to improve participants' health. Ongoing follow-up ensures that services and supports are being accessed. Outreach, health education, and depression screening are also available.

The VDH administers several federally funded **community nutrition programs** through its Division of Community Nutrition, located in the Office of Family Health Services. The largest of these programs is the VDH **Special Supplemental Nutrition Program for Women, Infants and Children (WIC)**, which is authorized and funded through the US Department of Agriculture. The WIC program aims to improve the health of pregnant women, infants, and children under age five through better nutrition and access to health care. Applicants must meet categorical, residential, income, and medical/bio-chemical risk requirements to be eligible for services.

WIC offices at local health departments screen potential participants for eligibility. The WIC Program ensures that eligible families, who might otherwise be unable to afford to eat properly, have access to healthy diets during pregnancy, breast-feeding, infancy, and early childhood to age five. Eligible participants are directed to WIC staff and peer counselors who provide: nutrition education and counseling, supplemental nutritious foods, breast-feeding promotion and support, and screening and referrals for other health, welfare, and social services. Program and eligibility information are available online <http://www.vdh.virginia.gov/ofhs/DCN/wic>.

Immunizations are critical to disease prevention and, ultimately, to public health. The **Virginia Vaccines for Children program** is a local health department program that partners with both public and private local practitioners to increase immunization levels for at-risk children. All vaccines required by law for school attendance may be obtained from local health departments, and vaccinations are available at no cost for individuals who are under the age of 19 and are uninsured, under-insured, enrolled in Medicaid, or are a Native American or Native Alaskan. The program conducts outreach and provides supplies of free vaccines to practitioners who then make them available to children with and without disabilities. The VDH central office, local health departments, and their community partners distribute information about the

program to the public, coordinate vaccine distribution to participating practitioners, and provide contact information on local participants.

The **Children and Youth with Special Health Care Needs (CYSHCN) program**, located within the Division of Child and Family Health under the VDH Office of Family Health Services, administers multiple service programs that work with families, service providers, and local communities to identify children with serious, persistent health care needs and to promote their optimal health and development. Its key network programs are described briefly below. Current core programs include, but are not limited to: Care Connection for Children, Child Development Services, the Bleeding Disorders Program, and the Sickle Cell Awareness Program. More information is available online at <http://www.vdh.virginia.gov/ofhs/childandfamily/childhealth/cshcn/>.

Care Connection for Children (CCC) is a network of six, regional **CCC Centers of Excellence** for children with special health care needs. The CCCs are located at the following sites.

- Washington County Community Services in Bristol
- Blue Ridge CCC at the University of Virginia Health System in Charlottesville
- Northern Virginia CCC at Inova Hospital in Fairfax
- Hampton Roads CCC at Children’s Hospital of the Kings Daughters
- Central Virginia CCC at VCU Health System
- Roanoke Area CCC at Carillion Medical Center

The CCC provides leadership to enhance specialty medical services, care coordination, medical insurance benefits evaluation and coordination, management of a limited CYSHCN (Children and Youth with Special Health Care Needs) pool of funds, information and referral to CYSHCN resources, family-to-family support, and training and consultation with community providers on CYSHCN issues.

Children with special health care needs who are eligible for CCC services have disorders that have a physical basis, have lasted (or are expected to last) at least 12 months, and produce one or more of the following:

- Need for health care and ancillary services over and above the usual for the child’s age, or for special ongoing treatments, interventions, or accommodations at home or school
- Limitation in function, activities, or social role in comparison with healthy age peers in the general areas of physical, cognitive, emotional, and social growth and development
- Dependency on one of the following to compensate for, or minimize limitation of, function, activities, or social role: medications, special diet, medical technology, assistive devices or personal assistance

CCC staff directly assists families of children diagnosed with qualifying medical disorders to obtain health care assessments and specialty medical care. Care Connection staff identifies, trains, and consults with potential community resources—particularly specialty medical services—to expand the available supply of providers and to establish family-to-family support networks.

The CYSHCN **Child Development Services Program** currently is a specialized program for children and adolescents suspected of having any one of, or a combination of, the following: a developmental delay or disability, learning problems, attention or hyperactivity disorders, and behavioral/emotional disorders. This program is financed by state and federal (Maternal and Child Health Block Grant-Title V) funds. At the time of this assessment, only five CDS clinics were in operation:

- the Southwest Virginia Child Development Clinic (Gate City),
- the Pediatric Neurodevelopmental Clinic at Carillion Medical Center for Children (Roanoke),
- the Shenandoah Valley Child Development Clinic (at James Madison University in Harrisonburg),
- the Virginia Commonwealth University Health System Clinic (Richmond), and
- the Child Development Clinic (Norfolk), which recently transitioned to the Children’s Hospital of Kings Daughters.

Each clinic has an interdisciplinary team consisting of these professionals: a pediatrician, a nurse, a social worker, an educational consultant, and a psychologist. Core services provided by each clinic include diagnostic assessment and treatment/care planning, follow-up care coordination, and referrals to local providers. Consultations are available from other pediatric specialists as needed. Throughout the communities served, clinic professional staff also offers consultation, training, and advocacy focused on promoting the healthy growth and development of children. More information is available at <http://www.vdh.virginia.gov/ofhs/childandfamily/childhealth/cshcn/care.htm>.

The **VDH Bleeding Disorders Program** within the CYSHCN serves Virginia residents of any age who have a congenital bleeding disorder, such as hemophilia A, hemophilia B, or von Willebrand Disease. These disorders may co-occur with other types of disability. Any Virginia resident diagnosed with a bleeding disorder may apply for the program, regardless of age or income, but financial criteria must be met to receive services at no cost. The state legislature enacted this program in recognition that the ongoing medical costs to treat such disorders often exceed the insurance coverage and household financial capacity of the individual and his/her family.

This program supports a system of coordinated, family-oriented services from multi-disciplinary teams, located at four regional **Comprehensive Bleeding Disorder Centers**. At this

time, three pediatric Comprehensive Centers exist statewide. They are located in Norfolk, Falls Church, and Charlottesville. A Center serving both children and adults is located in Richmond. Each Center's team consists of specialists from various professions: physicians, nurses, social workers, physical therapists, orthopedic surgeons, dentists, genetic counselors, nutritionists, and educators. The teams develop and implement plans that address the individual's array of needs, and they assist families in coping with emotional, social, financial, educational, and workplace concerns. While outreach, direct services, and referrals are aimed at the general population, a program emphasis is on outreach to health care professionals to promote identification of and care for Virginians with these inherited conditions. Reciprocal referrals between the Comprehensive Bleeding Disorder Centers and disability service agencies occur as a result. More information is available at <http://www.vdh.virginia.gov/ofhs/childandfamily/childhealth/cshcn/bleedingdisorders/index.htm>.

Another important VDH service within the CYSHCN program is the **Sickle Cell Awareness Program**, which offers detection and treatment of sickle cell disease for all Virginians. All Virginia newborns are screened at birth for sickle cell disease through the Virginia Newborn Screening Program (described earlier), which includes sites at local health departments. Screening results are typically provided to the parents through their pediatrician. These and other referral sources direct families to **Pediatric Comprehensive Sickle Cell Clinics**, located in four major regional medical centers, for education, counseling, care coordination, and treatment. Additional community and professional educational and support services are offered through Community-Based Sickle Cell Programs. Although there are no financial eligibility requirements to receive services, each clinic offering services may charge fees for direct services based on income. For more information, go online to <http://www.vdh.virginia.gov/ofhs/childandfamily/childhealth/cshcn/sickleCell/>.

As noted in the introduction to this chapter, oral health is important to everyone's overall health and wellness. Maintaining good oral hygiene should begin in infancy and continue throughout a person's life. The **VDH Dental Programs** website offers online visitors numerous fact sheets and educational materials on how to maintain good dental hygiene as well as on local dental resources. It is located at <http://www.vdh.virginia.gov/ofhs/childandfamily/dental/>.

Local health departments are the point of contact for services through their dental clinics or staff. Although historically VDH-supported dental clinics have been a "safety net" resource, most are now transitioning to a model of prevention-only services. A VDH directory of dental programs from January of 2010 noted that clinical dental services were provided in 25 health districts at 54 different locations. A 2012 VDH presentation reported that dental clinics in 17 health districts were in operation. According to the current Dental Transition Plan, only three health districts will continue to have full dental clinic operations in the future. The localities in those districts were identified as having a "critical, unmet need" due to a lack of "safety net" dental services. (Details of this transition are described in the Introduction to this chapter, beginning on page 159, and progress reports are listed in the **Chapter References**.)

The dental clinics that remain in operation have provided and will continue to provide services primarily for pre-school and school-age children based on income eligibility. Eligibility for these services may be determined by school lunch status and/or family income. Dental services may be provided at health department clinics or at dental trailers placed on school property. Adult dental care may be available on a limited basis in certain localities. According to a VDH presentation, in SFY 2011, VDH dental clinics had over 35,000 visits. Of the total services provided, 31 percent were diagnostic; 44 percent were preventive; and 25 percent received treatment. A total of 20,350 individuals were served that year, and 72.3 percent of those patients were children/youth and 27.7 percent were adults. Of the total number of people served, 48.6 percent were enrolled in Medicaid.

Within the VDH Division of Child and Family Health, preventive education initiatives are conducted for various populations. The **Bright Smiles for Babies** program specifically targets children from birth to age three who are at highest risk for dental decay. Services include dental screening and risk assessment, fluoride varnish application, and oral health education and guidance to parents. This program also provides training and education specifically for parents/guardians and caregivers of children with special health needs, including youth with developmental and other disabilities.

To promote improved oral health at elementary, middle and high schools, the Dental Health Unit has developed an oral health curriculum. It is comprised of six modules with lesson plans that complement the health education Standards of Learning (SOLs). The curriculum goal is to promote positive health behaviors by students. The curriculum is available for use by health or physical education teachers, school nurses, and other school staff as well as by School Health Advisory Boards.

In addition, to educate Virginia's adults about maintaining good oral hygiene across the lifespan, the VDH Division of Dental Health provides dental hygiene education for adults and the elderly through its initiative, **Beyond the Smile: The Campaign for Adult Oral Health**. This program provides training programs, presentations, educational materials and resources on oral health both to the general public as well as to health care and other professionals. Current educational programs include, but are not limited to:

- Virginia's Oral Cancer Project
- Diabetes and Oral Health
- Oral Health for the Elderly and Disabled
- Senior Smiles
- Oral Health and Overall Health-A Healthy Body Begins Here

Both VDH and local health departments provide training and educational resources for dentists and other health care providers to increase their skills in caring for young children and

others with special needs. A searchable database of Virginia dentists who provide care for individuals with special needs can be found at <http://www.vahealth.org/dental/>.

Since the mid-1980s, the spread of HIV and AIDS has been a growing health concern. An infant may be exposed to and contract HIV in utero through his/her infected mother. Men and women of any age may contract HIV through unprotected sex with an infected partner. As noted on the VDH website, individuals with cognitive and learning disabilities are at greater risk for contracting and spreading HIV/AIDS and have been identified by VDH as a population of special interest in its efforts to prevent spread of this disease.

The **VDH HIV Care Services** program provides outreach, referrals, and assistance to individuals of any age with HIV or AIDS. This program is funded through the federal Health Resources and Services Administration as authorized by the Ryan White Treatment Extension Act. A major program within the larger program is the **AIDS Drug Assistance Program (ADAP)**. ADAP provides medications for low-income, uninsured individuals with HIV/AIDS. The remaining funds provide HIV care services that are specifically targeted to deliver medical care and support services to eligible individuals living with HIV/AIDS. The Ryan White Treatment Extension Act's Part B funding is the payer of last resort.

The income requirement for HIV Care Services and the ADAP is currently 400 percent of the Federal Poverty Level (FPL). Program coordination is provided centrally by VDH HIV Care Services and regionally by "consortia" working in collaboration with local health departments and community partners. Three Health Regions (Northern, Northwest, and Southwest) in Virginia have a Regional Consortium that coordinates and facilitates Ryan White **Part B funds**. The Regional Consortia are a point of contact for accessing information on all Ryan White funding, not only in their respective region, but also throughout the State. In the Central and Eastern Regions, services are provided through a network of direct service providers. Information on the Central and Eastern Regions, as well as the rest of the State, can be accessed by calling HIV Care Services at (855) 362-0658. **Table 26** provides data on the number of individuals served under each program.

Table 26. Number Served by VDH HIV/AIDS Programs		
Year	ADAP Medications	Ryan White Care and Support Services
April 2010 - March 2011	3,952	6,807
April 2011 - March 2012	3,468	6,936
April 2012 - March 2013	4,647	6,962

To reduce the risk of cancer among low-income women who are uninsured or underinsured and age 18 through 64, **Every Woman's Life (EWL), the Breast and Cervical Cancer Early**

Detection (BCCED) Program, provides clinical breast exams, mammograms, Pap tests, and pelvic exams. Services are available from a network of 32 public and private nonprofit providers that serves over 7,600 women annually. The EWL program provides follow-up to ensure that participants receive the recommended screenings and appropriate services. Women can locate the nearest screening sites for the Every Woman’s Life (EWL) program by calling 866-395-4968 (toll-free) or e-mailing the program through its website at <http://www.vahealth.org/ewl/>. This program is located within the Division of Prevention and Health Promotion of the Office of Public Health Services.

In addition to the direct health care services described, VDH operates numerous **education and outreach programs** for wellness and disease prevention through eight **Area Health Education Centers (AHECs)**, coordinated by Virginia Commonwealth University. Each AHEC is a unique, regional partnership of statewide and local educational resources, professional networks, public and private health care providers, VDH health districts, and municipal health departments. Their projects and resources are specific to the communities that they serve and primarily target areas that have shortages of health care providers and large populations of Virginians at risk for poor health habits and chronic health conditions. Individual projects undertaken by AHECs vary, but generally, they seek to increase the number of health care providers in underserved areas, address educational, physical, and attitudinal barriers that restrict access to health and wellness services, and identify underserved members of the community and direct them to appropriate services. As a result, expanded and improved health care service for people with disabilities is frequently a goal and outcome of AHEC activities.

Child and family health services programs at the Virginia Department of Health (VDH) collaborated to create **Bright Futures Virginia**, an information resource for families and health professionals. While Bright Futures does not specifically target families of children with disabilities, its “Guidelines” increase general awareness of what is developmentally appropriate and encourage routine, periodic screening for developmental delay. Its framework can then be used to assess the physical and mental health needs of children from birth through adolescence, determine if their progress is developmentally appropriate, and promote healthy growth and a smooth transition from pediatric to adult health services. The Bright Futures Virginia website provides information in video and printable formats that parents, caregivers, and health and human services professionals can access for up-to-date information on developmentally based well child care and anticipatory guidance. Launched in 2009, VDH reports that this webpage now receives more than 20,000 visits per month. Infant growth, toilet training, discipline, and behavior are the top video topics accessed. It is at <http://www.vahealth.org/brightfutures>.

The VDH **School Health Program** collaborates with the Virginia Department of Education (VDOE) in the supervision and coordination of school health nursing services in the Commonwealth. State school health specialists develop and promote guidelines, educational materials, training programs, and other resources for all public school divisions as well as

private and parochial schools. These guidelines and resources address health services for all students, with and without disabilities.

VDH's **Youth Suicide Prevention** program produces and distributes educational materials and conducts training for families, educators, and local service providers to raise public awareness and reduce the incidence of youth suicide. These materials include important referral information for Virginia's disability services and are available free of charge from the program's website at <http://www.vahealth.org/Injury/preventsuicideva/index.htm>, the VDH central office, and the program's community partners.

4. Cost and Payment for VDH Services

Numerous sources, such as the Kaiser Family Foundation and the US Surgeon General, report that individuals with disabilities are typically poorer and are less likely to have private health insurance than the general population, making them necessarily more reliant on public insurance programs and other government-subsidized services. Health services provided and expenditures under the Commonwealth's Medicaid and CHIP health insurance programs are described in detail in the **Medicaid** chapter of this *Assessment*. Focus here is on funding revenue and expenditures for the **Virginia Department of Health (VDH)**.

In general, individuals pay for health care costs in several ways:

- directly out-of-pocket (in-full or as co-payment);
- indirectly through private health insurance purchased by an individual or family;
- private insurance through employers; or
- through public insurance programs (Medicaid, Medicare and the Children's Health Insurance Program, or CHIP).

Depending on income or if they are uninsured or underinsured, individuals may access various government-operated medical or dental services, such as those provided by local health department clinics. These providers may require co-payments or have sliding scale fees. Fees for VDH-supported services are based on medical and income criteria. These services typically are funded through a mixture of federal, state, and local public monies. The Commonwealth's General Assembly may allocate monies for health services by state fiscal year either from its General Funds or from dedicated revenue sources (such as user fees).

VDH received a total of:

- \$574,648,398 in appropriations in SFY 2012;
- \$621,434,928 in SFY 2013; and
- \$626,963,628 in SFY 2014.

It is important to note that, in conducting its multiple, mandated functions, VDH typically spends 88 percent of its annual budget in local communities. VDH funding to local, mandated health services is based on a complex formula set through collaborative planning between VDH and localities.

Budget allocations for selected categories of community health services that directly impact the lives of citizens for SFYs 2013 and 2014 illustrate the economic impact of VDH services. For both SFY 2013 and 2014, the annual budget was stable for:

- Local Dental Services, \$7,036,703 each year;
- Local Immunization Services, \$10,986,239 annually;
- Local Communicable Disease Investigation, Treatment, and Control, \$17,644,195 annually.

Appropriations decreased 1.7 percent for:

- Local Maternal and Child Health Services.

Funds for health services targeted at pregnant women and children went from:

- \$42,299,966 in SFY 2013 to
- \$41,582,329 in SFY 2014.

The *2013 VDH Agency Strategic Plan Executive Progress Report* notes that local health departments are funded jointly by VDH and local governments—a funding model unique among state agencies. VDH and the local government have a contractual agreement for local health clinic operations. A formula based on each locality’s capacity for revenue generation by a clinic determines the amount of each locality’s match payment, which may vary from 18 to 45 percent of total clinic operational costs. The report is available online at https://solutions.virginia.gov/pbreports/rdPage.aspx?rdReport=vp_Agency&rdAgReset=True&Agency=601.

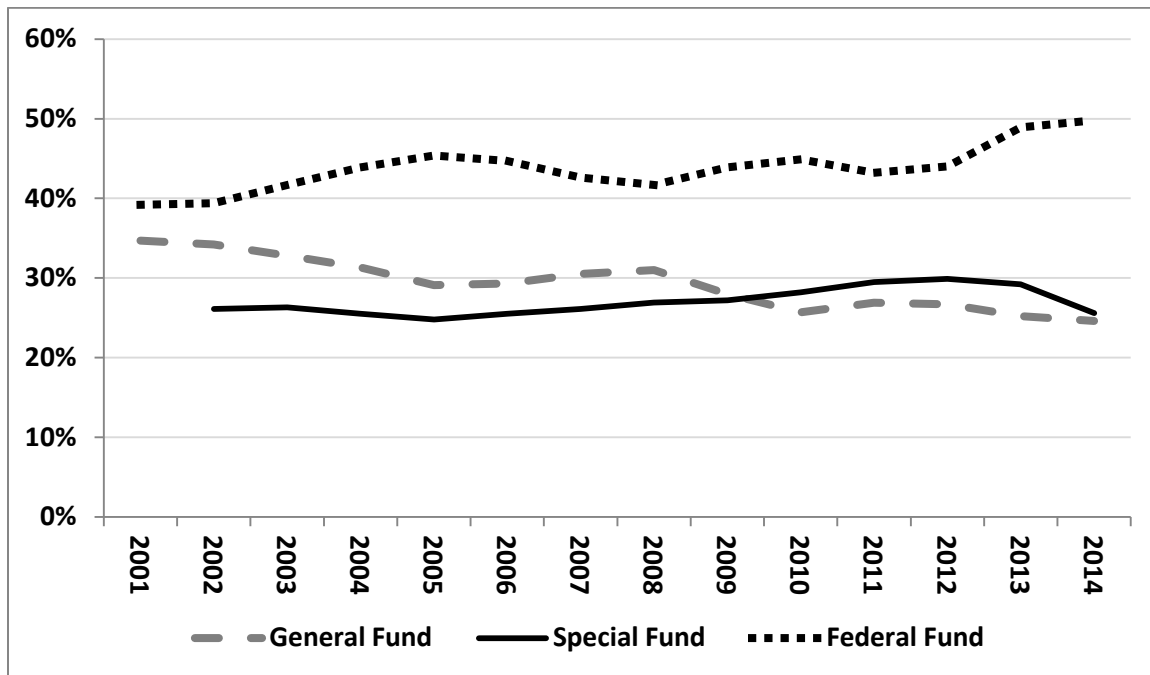
That same *Progress Report* points out that half of the annual VDH budget now comes from the federal government. In SFY 2014, VDH funding came from the following sources:

- 50 percent from federal grants and contracts;
- 25 percent from state General Funds;
- 13 percent from service fees and charges;
- 9 percent from local government funds for local health departments;
- 3 percent from dedicated special revenues (such as non-VDH-related fees and fines);
and

- less than 1 percent from private grants, donations, and gifts.

Since 2001, VDH reports that the agency has become increasingly reliant on federal funding, which increased as state General Fund allocations decreased. This funding pattern, in turn, caused VDH service priorities to shift more toward those set by the federal government than to state priorities. Since the terrorist attacks of 9/11 in 2001, federal funds increased for services such as epidemiology, disease prevention/control, and immunization. Based on data provided by the VDH Budget Office, **Figure 16** depicts this historical trend. It shows the percentage of the annual appropriations provided by each funding source by category.

Figure 16. Proportion of VDH Appropriations for SFYs 2001–2014



Between state fiscal years (SFYs) 2008 and 2014, total VDH funding actually increased, but most of the increase was from federal funds. Part of the federal increase, according to the VDH Budget Office, was due to VDH assumption of responsibility for administration of two food programs from the US Department of Agriculture: the Child and Adult Care Food Program and the Summer Food Service Program. **Figure 17** and **Figure 18** show the increasing federal role in the VDH annual budget for services between SFYs 2008 (**Figure 17**) and 2014 (**Figure 18**). Fiscal data were provided by the VDH Budget Office. Special funds are revenue from various service fees and charges, a large portion of which is from fees for environmental, medical, and personal care services provided by local health departments. Other fees come from waterworks operations, health care facilities, vital records, and other sources. As the charts indicate, the share of federal funding grew 29 percent over these years while state General Fund appropriations decreased by 8 percent.

Figure 17. VDH Funding by Source for SFY 2008

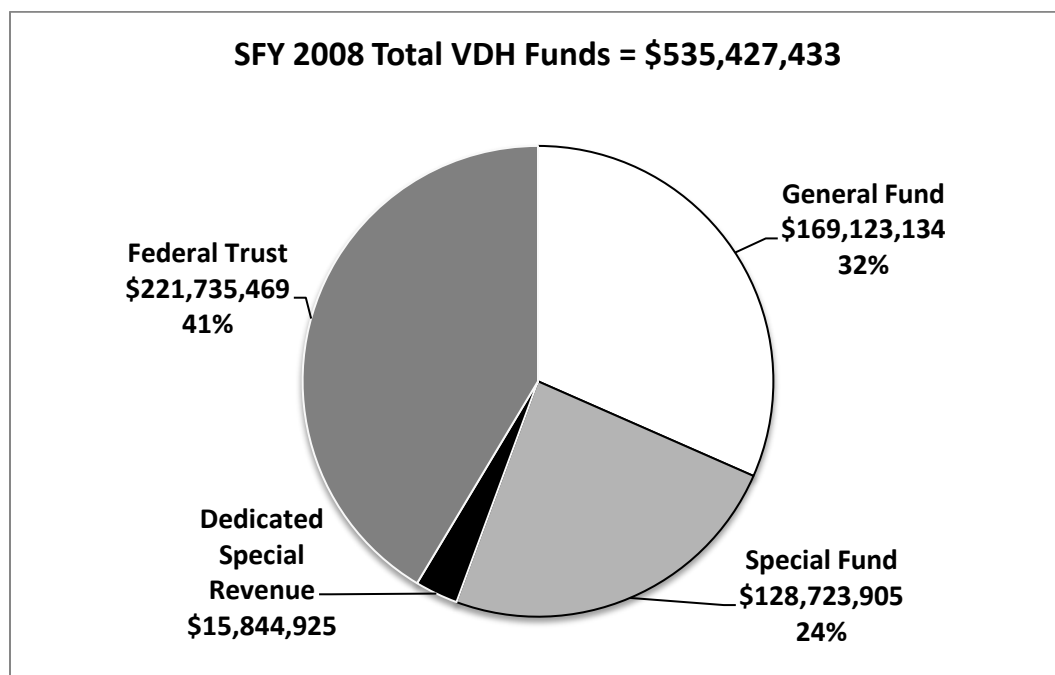
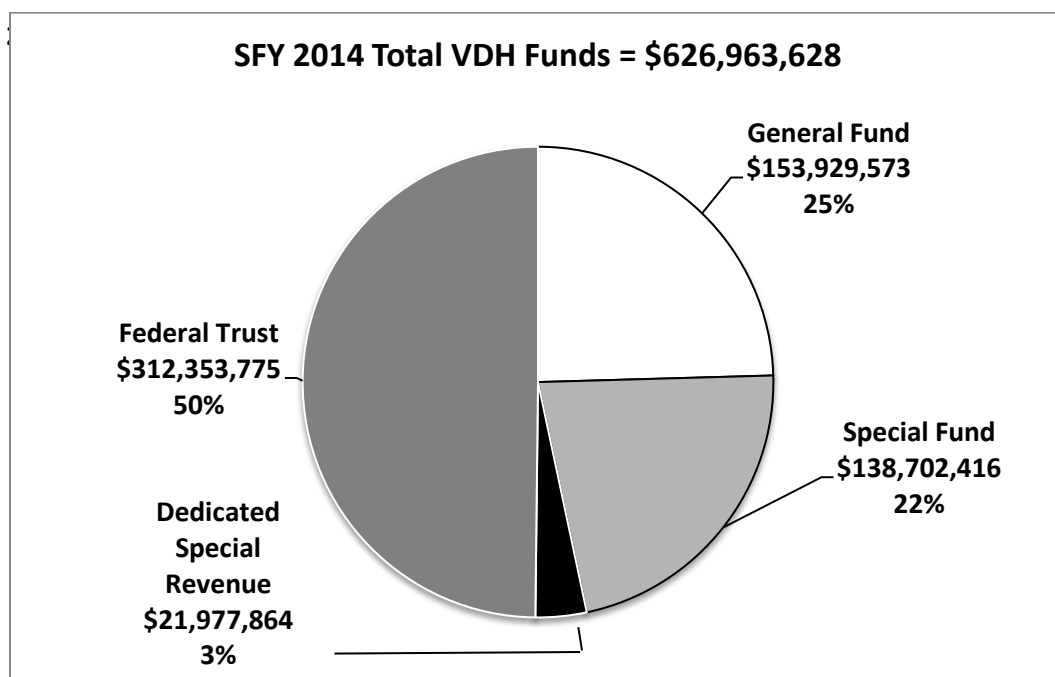


Figure 18. VDH Funding by Source for SFY



During the same SFYs, staffing levels at the Department of Health (VDH) were more reliant on Non-General Funds (NGF)—federal funds and special revenue from fees and grants—than on state General Funds (GF).

Table 27. Number of VDH Staff Positions by Funding Source			
SFY 2008	GF: 1,664 positions	NGF: 2,107 positions	Total = 3,771 positions
SFY 2014	GF: 1,544 positions	NGF: 2,215 positions	Total = 3,759 positions

Growing reliance on federal funds is problematic. For example, the federal government shut down in the fall of 2013, creating a significant threat to VDH operations. The VDH commissioner (then Cynthia Romero, M.D.) advised the state House Appropriations Health and Human Resources subcommittee:

Had the debt ceiling not been resolved, the resulting cash flow problems presented VDH with the potential furlough of approximately one third of our workforce.

In turn, both services to Virginians in need and local economies would have been negatively impacted.

5. Monitoring and Evaluation of VDH Services

It is not possible to address the entire system for monitoring and evaluating the performance and responsiveness of the health care system in this *Assessment*. What follows is a general description of quality assurance mechanisms related to the services described previously. More information, including detailed monitoring and complaint procedures and compliance reports, where available, may be found using the **Chapter References**.

The **Virginia Department of Health (VDH) Office of Licensure and Certification** is responsible for licensing, monitoring, and managing compliance for a wide range of public and private health care facilities and service providers such as hospitals, outpatient clinics, certain laboratories and other testing facilities, nursing facilities, home care organizations, and hospice programs. Information on its quality assurance activities relative to direct services for people with disabilities may be found in the **Community Living Supports** and **Institutional Supports** chapters of this *Assessment*.

The VDH Office of Licensure and Certification is also responsible for certification of managed care health insurance plans under Titles XVIII and XIX of the federal Social Security Act (42 USC §§ 1395 and 1396 et seq., respectively). This office is also the state's official survey agency for providers that are eligible for reimbursements under Medicaid and Medicare. Specific certification, inspection, monitoring, and compliance requirements vary by type of service, and details can be found on the office's website at <http://www.vdh.virginia.gov/OLC/index.htm> along with procedures for submitting and resolving service complaints. The **Virginia Department of Medical Assistance Services (DMAS)** is charged with monitoring expenditures, preventing fraud and abuse, and providing quality assurance for the State's public health insurance programs. Information on these agencies' functions can be found in the **Medicaid** chapter of this *Assessment*.

The **Virginia Department of Health Professions (DHP)** administers, supports, and coordinates 13 DHP regulatory boards that set, monitor, and enforce standards of practice in 80 different health-related professions, which include over 350,000 health care workers statewide. Health professions regulated through the DHP include, but are not limited to:

- audiology and speech language pathology,
- counseling,
- psychology,
- social work,
- physical therapy,
- optometry,
- dentistry,
- medicine,
- nursing,
- pharmacy, and
- long-term care administrators.

As noted on the DHP website, each board works

to ensure safe and competent patient care by licensing health professionals, enforcing standards of practice, and providing information to health care practitioners and the public.

These boards develop regulations, receive complaints, and make case decisions regarding whether a provider is in violation of requirements for obtaining or retaining a license.

The DHP grants licenses, certifications, and registrations, handles concerns and complaints about service providers, and collects workforce data. To assist the public, the DHP has an online system for checking the current licensure status of health professionals, practitioners' records in the Board of Medicine's database, and the results of recent case decisions on complaints. Lists of covered professions, information on professional standards, complaint procedures, and forms are available on its website at <http://www.dhp.virginia.gov> or by contacting the DHP directly.

C. DBHDS Regional Community Support Centers

In 1998, the Department of Behavioral Health and Developmental Services (DBHDS) began efforts to increase health care availability and capacity for persons with intellectual disabilities (ID) through creation and expansion of Regional Community Support Centers (RCSC). The RCSCs were intended to offer clinical services that were otherwise unavailable or not accessible from

community health care providers and other resources. RCSCs, supported by state General Funds, have offered outpatient services through clinics located in and operated by each of the five DBHDS Training Centers. The Training Centers are state-operated intermediate care facilities for individuals with intellectual and developmental disabilities. For more information on the Training Centers and other institutions in Virginia, see the **Institutional Supports** chapter of this *Assessment*.

The first RCSC was a demonstration pilot at the Northern Virginia Training Center, which obtained annual appropriations. Facility staff (or sometimes contractors) provided the services. Although each facility periodically offered services to individuals in the community, state funding to establish and maintain an RCSC at each facility did not occur until several years later. In state fiscal year (SFY) 2006, DBHDS received legislative appropriations to begin operating RCSCs at Central Virginia and Southwestern Virginia Training Centers; and in 2008, appropriations were made for Southside Virginia and Southeastern Virginia Training Centers.

Service priorities for each RCSC were based on regional service needs and gaps for individuals with ID through collaborative planning with local Community Services Boards and other stakeholders. As a result, the scope and type of RCSC services being provided have varied somewhat by facility. In addition, in partnership with colleges and universities, the RCSCs can provide training to students pursuing health care careers, thereby potentially expanding a trained community workforce available to serve individuals with ID and developmental disabilities (DD).

Through the 2012 Settlement Agreement with the US Department of Justice (DOJ), DBHDS and the Commonwealth made a commitment to expand community service capacity and to strengthen efforts to ensure individual health and safety in communities statewide. At the time of this assessment, DBHDS plans to transform the RCSCs by moving them into the community and by developing public-private partnerships for expanded outpatient services under the new name, the **Developmental Disability Health Support Network**. This transition is in process. An initial report on the transition was released in the spring of 2014, but it did not contain comprehensive details. More comprehensive information on the transition and future network configuration will be released later in 2014.

1. Eligibility for RCSC Services

The RCSCs provide diverse clinical services and consultation to individuals with ID/DD and their families who either (1) have been discharged from a Training Center to a community residence, or (2) are community residents who have been referred by a local Community Services Board (CSB) or Behavioral Health Authority (hereafter referred to as CSBs). Priority for the limited services has been to provide key supports that are not otherwise available to enable participants to live successful lives in their communities. Residential service providers and health care professionals in the community may be eligible to receive clinical consultations or staff training from RCSC staff to improve services to individuals. They, too, must contact their local CSB to request RCSC training or consultation services.

2. Access to and Delivery of RCSC Services

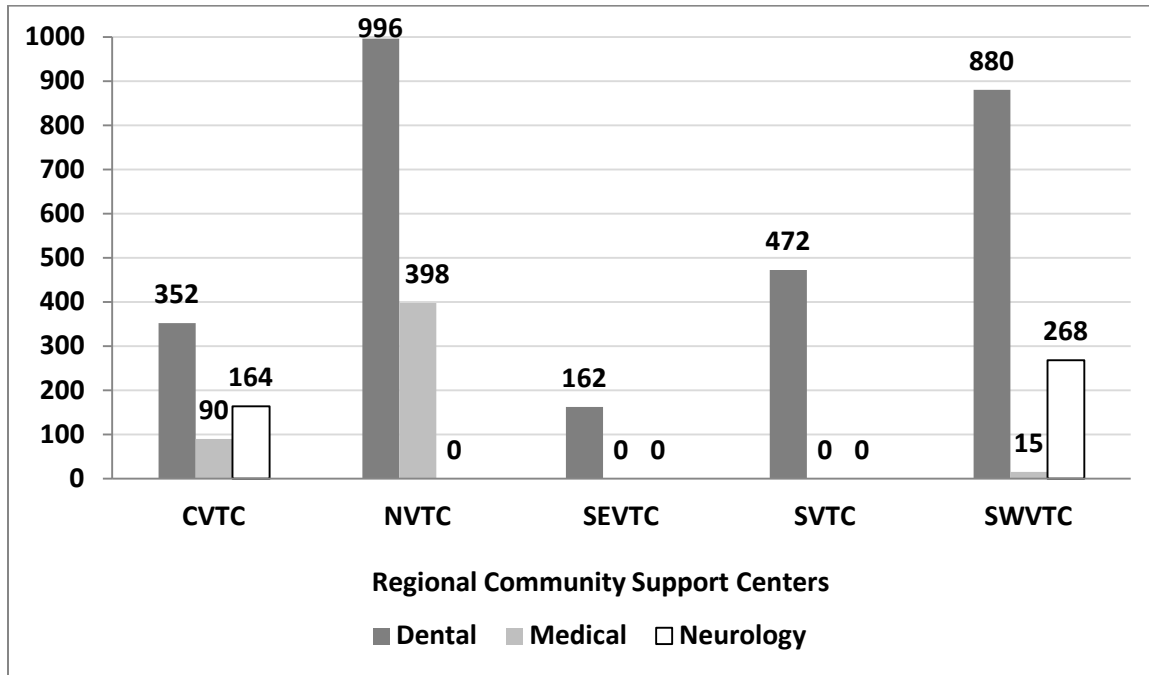
The DBHDS only had RCSC utilization data available for SFY 2012, which was prepared as part of its transition plans. That year the five RCSCs provided clinical and related services to a total of 4,894 individuals (unduplicated) in their communities. Because of regional prioritization for RCSC services and funding levels, variation across RCSCs has existed in both the total number of persons served and the type of services received. The total number served at each RCSC in SFY 2012 is as follows:

- 369 at Southside Virginia Training Center (SVTC) RCSC,
- 454 at Southeastern Virginia Training Center (SEVTC) RCSC,
- 739 at Central Virginia Training Center (CVTC) RCSC,
- 1,550 at Southwestern Virginia Training Center (SWVTC) RCSC, and
- 1,782 at Northern Virginia Training Center (NVTC) RCSC.

Of the total served, the SVTC RCSC served 7.5 percent that year; the SEVTC RCSC, 9.3 percent; the CVTC RCSC, 15.1 percent; the SWVTC RCSC, 31.7 percent; and the NVTC RCSC, 36.4 percent.

The data for each RCSC identify the number of people receiving various types of clinical services. The following graphs (**Figure 19** and **Figure 20**) illustrate the difference in RCSC service levels in each region that year. Individuals typically received more than one service at an RCSC during the year, so counts are duplicative across services. The NVTC RCSC was the only facility that provided therapeutic recreation, serving 191 individuals in SFY 2012; and that count is *not* included in either chart. **Figure 19** depicts the number of individuals who received dental, medical, or neurological services at each RCSC.

Figure 19. Number Provided with RCSC Health Services in SFY 2012



Preventative dental care for adults is not covered by Medicaid in Virginia, and reimbursement rates for **complex medical care**, which is covered, may not be sufficient to encourage providers to serve the ID/DD population. Not surprisingly, all RCSCs provided dental care in SFY 2012. For the SVTC RCSC, dental care was the only direct health service provided. Statewide, the RCSCs provided dental care to 2,862 individuals, 65.5 percent of whom were served at the NVTC and SWVTC RCSCs. NVTC served 996 dental patients, and the SWVTC RCSC served 880.

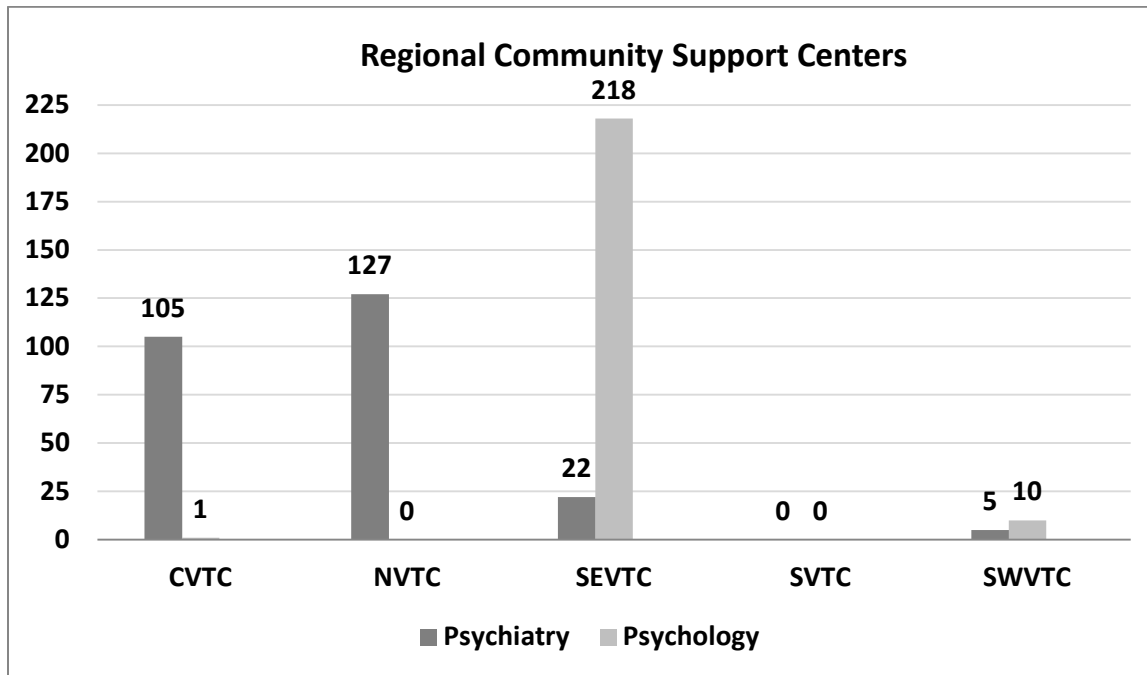
To expand dental service capacity in the community and offer dental services to adults with ID/DD, over the last several years the Northern Virginia Training Center has partnered with the ARC of Virginia, the VCU Health System School of Dentistry, the Virginia Dental Association, and the Virginia Oral Health Coalition. NVTC or its partners have successfully applied for grants and donations to expand these capacities.

Also in SFY 2012, a total of 503 individuals received some type of **medical care** and 432 received **neurological services** through the RCSCs. The NVTC RCSC also had the highest number of individuals receiving medical services with 398 patients, accounting for 79.1 percent of all RCSC medical services provided that year. Only CVTC and SWVTC, both located in more rural and underserved areas, provided neurological services.

Psychological and psychiatric services provided through RCSCs, with the exception of the SVTC, included assessment, consultation, and treatment. A total of 229 individuals received

psychological services among four RCSCs in SFY 2012; and a total of 259 received psychiatric services. As shown in **Figure 20**, the SEVTC RCSC provided the vast majority of psychological services with 218 cases that year, and the RCSCs at CVTC and NVTC provided most of the psychiatric services with 105 and 127 cases, respectively.

Figure 20. Number Receiving RCSC Psychological and Psychiatric Services in SFY 2012



In addition, each RCSC offered training of community providers and, in partnership with colleges and universities, training for students through internships. In SFY 2012, a total of 925 staff working in residential and health care settings were trained by RCSCs to improve community services and supports to individuals with ID/DD, and a total of 177 interns in various fields were trained, which may increase service capacity and quality in the future. **Table 28** provides the number trained by each RCSC location in SFY 2012.

RCSC	# Community Staff	# Interns
CVTC	688	101
NVTC	62	62
SEVTC	40	8
SVTC	57	2
SWVTC	78	4

Table 29. Number of Staff/Interns Trained in ID/DD by RCSCs in SFY 2012		
RCSC	# Community Staff	# Interns
TOTALS	925	177

The RCSC at CVTC trained 74.4 percent of the 925 community provider staff members trained and 57.1 percent of the interns trained system-wide. NVTC trained 35 percent of the 177 interns trained at RCSCs in SFY 2012.

3. Available RCSC Services

In collaboration with the local Community Service Boards (CSBs), families and other stakeholders, each RCSC developed a service array that best addressed unmet needs in the region. Limitations in the range and scope of services provided have existed due to different funding levels through state appropriations. (See the **Funding for RCSC Services** section below for more details.) The RCSCs are staffed by Training Center personnel as well as by private clinicians under contract with the facility. In general, clinical services provided by the RCSCs in recent years have included the following:

- psychological or behavioral consultation and psychological testing;
- dental procedures;
- laboratory, medical and preventative medical services;
- pediatric neurology;
- nursing and nutrition consultation;
- physical therapy;
- rehabilitative engineering;
- speech and language therapies; and
- therapeutic recreation services (only at NVTC).

Over the past ten years, a unique regional program at Southwestern Virginia Training Center (SWVTC) RCSC—**Pathways**—has existed to serve individuals with ID who are in communities and have either a co-occurring mental illness or have severely challenging behaviors that threaten their continued community residence. Begun in August of 2003, the Pathways program provides diagnostic consultation, treatment (medical, behavioral, and psychiatric), and short-term stabilization for that population. The Pathways program includes both outpatient services and short-term residential care, which is at a designated unit of eight beds certified as an intermediate care facility for individuals with intellectual disabilities (ICF/IID). The maximum length of stay in a Pathways residential unit is 90 days. All referrals must be made by a local Community Services Board (CSB). Pathways oversight is provided by a regional Pathways

Council comprised of representatives from the CSBs (ID and mental health staff), the SWVTC, and Southwestern Virginia Mental Health Institute (a state DBHDS psychiatric facility).

4. Funding for RCSC Services

Started as a pilot project at Northern Virginia Training Center (NVTC) in 1998, the RCSCs spread slowly across the system. Each developed different levels of capacity based on state funding and on regional service gaps to be addressed. Some services, especially preventative dental care to adults, are not reimbursed by Medicaid or some private insurers, and thus have been dependent on state General Funds (GF) through legislative appropriations. Each Training Center provides various in-kind services, such as use of its dental clinic, and either provides or contracts for professional staff to provide services. From SFY 2006 through 2013, the RCSC at NVTC received \$350,000 annually in state GF; and the other four RCSCs received \$200,000 each.

As reported by DBHDS, in SFY 2012, total expenditures for RCSC services were \$1,447,257 system-wide. By facility, the RCSC at SVTC spent the least amount on services (\$167,631); and the RCSC at NVTC, the most (\$893,614). RCSC SFY 2012 expenditures at CVTC were \$214,211 and \$171,801 at SEVTC.

5. Monitoring of RCSC Services

Like any other health care service, professional clinical services at the RCSCs are licensed and monitored by the Virginia Department of Health; and individual clinical professionals must meet the licensing standards as set forth through the Department of Health Professions and their individual professions. (See the previous section on **Monitoring and Evaluation of VDH Services** for details.)

In addition, as part of the state Training Center staff, RCSC clinicians provide health care services to facility residents as well as individuals living in communities. The RCSC program must meet any applicable facility, staffing, professional, and equipment standards required by the US Centers for Medicare and Medicaid Services (CMS) for intermediate care facilities for individuals with intellectual disabilities (ICF/IID). More information is available about monitoring of ICFs/IID in the **Institutional Supports** chapter of this *Assessment*.

D. Chapter References

Links to websites and online documents reflect their Internet addresses in June of 2014. Some documents retrieved and utilized do not have a date of publication.

1. Non-state Websites Referenced

Area Health Education Centers

<http://www.ahec.vcu.edu>

Association of University Centers on Developmental Disabilities

<http://www.aucd.org>

Healthy People 2020

<http://www.healthypeople.gov/2020/default.aspx>

Kaiser Family Foundation State Health Facts

<http://www.statehealthfacts.org>

Partnership for People with Disabilities at Virginia Commonwealth University

<http://www.partnership.vcu.edu/>

US Centers for Disease Control (CDC)

<http://www.cdc.gov>

Adult Oral Health

http://www.cdc.gov/OralHealth/children_adults/adults.htm

Behavioral Risk Factor Surveillance System

<http://www.cdc.gov/brfss>

Disability and Health

<http://www.cdc.gov/ncbddd/disabilityandhealth/>

US Office of the Surgeon General

<http://www.surgeongeneral.gov>

Reports

<http://www.surgeongeneral.gov/library/reports/oralhealth/index.html>

2. Virginia State Websites Referenced

Code of Virginia

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

Department of Health

<http://www.vdh.virginia.gov>

Division of Child and Family Health

<http://www.vdh.virginia.gov/ofhs/childandfamily/>

Behavioral Risk Factor Surveillance System

<http://www.vdh.virginia.gov/OFHS/brfss/>

Child Health Programs

<http://www.vdh.virginia.gov/ofhs/childandfamily/childhealth>

Children and Youth with Special Health Care Needs (CYSHCN)

<http://www.vdh.virginia.gov/ofhs/childandfamily/childhealth/cshcn/>

Bleeding Disorders Programs

<http://www.vdh.virginia.gov/ofhs/childandfamily/childhealth/cshcn/bleedingDisorders/>

Care Connection for Children

<http://www.vdh.virginia.gov/ofhs/childandfamily/childhealth/cshcn/care.htm>

Child Development Services

<http://www.vdh.virginia.gov/ofhs/childandfamily/childhealth/cshcn/developmentServices.htm>

Sickle Cell Awareness Programs

<http://www.vdh.virginia.gov/ofhs/childandfamily/childhealth/cshcn/sickleCell/index.htm>

Dental Health

<http://www.vahealth.org/dental>

Early Childhood Health Programs

<http://www.vahealth.org/childadolescenthealth/EarlyChildhoodHealth/>

Genetics and Newborn Screening

<http://www.vahealth.org/gns/>

Newborn Screening Program

<http://www.vahealth.org/vnsp/>

Virginia Cares

<http://www.vahealth.org/gns/vaCares.htm>

Virginia Early Hearing Detection and Intervention

<http://www.vdh.virginia.gov/ofhs/childandfamily/childhealth/hearing/>

Loving Steps (Healthy Start Initiative)

<http://www.vdh.virginia.gov/ofhs/childandfamily/ReproductiveHealth/pregnancy/lovingSteps/>

Prevention and Health Promotion

<http://www.vdh.virginia.gov/ofhs/prevention/>

School Health

<http://www.vahealth.org/childadolescenthealth/schoolhealth/>

Division of Health Statistics

<http://www.vdh.virginia.gov/healthstats/>

Division of Immunization

<http://www.vdh.virginia.gov/Epidemiology/Immunization/>

HIV/AIDS Programs

<http://www.vdh.virginia.gov/epidemiology/DiseasePrevention/Programs/HIV-AIDS/index.htm>

Virginia Vaccines for Children

<http://www.vdh.virginia.gov/epidemiology/Immunization/VFC/index.htm>

Office of Licensure and Certification

<http://www.vdh.virginia.gov/OLC/>

Office of Minority Health and Health Equity

<http://www.vdh.virginia.gov/OMHHE/>

Department of Health Professions

<http://www.dhp.virginia.gov>

Joint Commission on Health Care

<http://jchc.virginia.gov>

Virginia Administrative Code

<http://leg1.state.va.us/000/reg/TOC.HTM>

Virginia Performs

<http://vaperforms.virginia.gov/>

3. Documents Referenced

- Association of University Centers on Disabilities (AUCD). (May 2010). *AUCD Summary of the Patient Protection and Affordable Care Act: A Detailed Summary of Provisions that Impact AUCD Network Programs*. Retrieved from https://www.aucd.org/docs/policy/health_care/Section%20by%20Section%20Summary%20of%20Prevention%20and%20Wellness%20Provisions.pdf
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- US Office of the Surgeon General. (2003) *National Call to Action to Promote Oral Health*. Rockville, MD: US Department of Health and Human Services, Public Health Service, National Institutes of Health, National Institute of Dental and Craniofacial Research. NIH Publication No. 03-5303. Retrieved from <http://www.ncbi.nlm.nih.gov/books/NBK47472/>

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- Virginia Department of Health. (2012, October). *Oral Health Plan: A Report to the General Assembly (RD 257)*. Retrieved from <http://leg2.state.va.us/DLS/h&sdocs.nsf/5c7ff392dd0ce64d85256ec400674ecb/e48f6f48d8ed436785257a1c005911f2?OpenDocument&Highlight=0,dental>
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Virginia Department of Health. (2014, January) *Report on Services Provided by Virginia Department of Health Dental Hygienists Pursuant to a "Remote Supervision" Practice Protocol 2013 (RD 30)*. Retrieved from <http://leg2.state.va.us/DLS/h&sdocs.nsf/a762cd2685f84d7a85256f030053196e/93cb9b724d6ed60085257c62005eab28?OpenDocument>