

VI. Community Living Supports

A. Introduction to Support Services for Community Living

The programs and services in this chapter, broadly referred to as “community supports,” enable individuals with disabilities to be as independent as possible and to be fully integrated into all facets of community life. State agencies operate, administer, license, or pay for services and supports 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*.

Several key factors impact the scope and availability of community-based disability services in the Commonwealth:

- the State’s economy;
- federal budget decisions (and indecision), especially regarding Medicaid and Medicare;
- state Medicaid reform, such as expansion of managed care; and
- Virginia’s Settlement Agreement with the US Department of Justice.

In this **Settlement Agreement with the US Department of Justice (DOJ)**, Virginia committed to numerous actions that would transform services for people with Intellectual Disabilities (ID) and Developmental Disabilities (DD) from institutions and institutional-based services to a focus on community living and community-based services. The target populations covered under the Agreement include individuals with ID or DD who reside in state-operated Training Centers or in private/nonprofit nursing facilities. It also includes all individuals who are already living in the community and are eligible for or on waiting lists for Medicaid ID or DD Waivers. Virginia made a 10-year commitment to these goals:

- significant expansion of community services available to individuals with intellectual (ID) and related disabilities;
- improved service oversight and quality assurance; and
- closure of 4 of the 5 Training Centers.

The **Department of Behavioral Health and Developmental Services (DBHDS)**, which leads implementation of the Agreement, took action in 2011 to address DOJ findings. In February of 2012, DBHDS presented a formal plan to the General Assembly. It set up interagency workgroups and internal project teams to ensure completion of the Agreement’s required actions. A court-appointed **Independent Reviewer** monitors progress made by DBHDS and the Commonwealth in fulfilling the system changes identified in the Agreement. The legislature

additionally requires regular formal reports on activities and progress by DBHDS. DBHDS regularly posts information online, including operational changes for case management, internal and legislative progress reports, Independent Reviewer reports, and many other Agreement documents, which can be accessed at <http://www.dbhds.virginia.gov/settlement.htm>.

As required by the Settlement Agreement, DBHDS worked to develop a new, regional **crisis intervention service** for adults (ages 18 or older) with ID and/or DD who also have either (1) a psychiatric condition or (2) challenging behaviors that negatively affect their quality of life. DBHDS contracted with the Institute on Disability (University Center for Excellence in DD) at the University of New Hampshire to implement a **Systematic, Therapeutic Assessment, Respite and Treatment** crisis model known as “**START.**” This evidence-based model emphasizes early intervention and crisis prevention for individuals with ID/DD through an integrated, statewide service system. Goals of the crisis program have been to enhance local service capacity and provide collaborative, cost-effective, person-centered supports based on comprehensive assessment, planning, and technical assistance, and to improve the clinical outcomes for these individuals. START consultants assisted DBHDS in program development and in training both Community Service Boards (CSBs) staff and new, regional crisis team members. Training included best practices for assessment, crisis intervention and treatment planning.

By late fall of 2013, all 5 regions had in operation both START mobile teams to respond to crises on a 24-hour, 7-days-a-week basis and centers for short-term, therapeutic respite care on either an emergency or planned basis. The mobile teams additionally engaged the individual and his/her family or caretakers to develop personal crisis prevention and support plans, and provided training to them for implementation of those plans. These regional teams conduct follow up on individuals over time to monitor service effectiveness and to address any emergent issues. An annual evaluation report, developed by the **University of New Hampshire Center for START (UNHC/START)**, states that 517 individuals were referred to the regional START programs during SFY 2013. A noted accomplishment was that the mobile teams achieved an average response time of less than 2 hours for face-to-face evaluations and immediate telephone response for on-call systems.

As part of program evaluation, DBHDS requires data collection by the mobile teams on the following for each individual:

1. demographics,
2. psycho-social factors,
3. psychiatric diagnoses (if any),
4. medical history,
5. history of psychiatric hospitalizations in the last 1-5 years,
6. presenting behaviors and issues, and

7. service utilization.

Data are analyzed at the regional and state levels. DBHDS provides program descriptions, information, and reports online at <http://www.dbhds.virginia.gov/ODS-default.htm>.

As of January 9, 2014, based on experiences and outcomes thus far, DBHDS renamed and modified the crisis service as the **Regional Educational Assessment Crisis Response and Habilitation (REACH) program**. Building on key tenets and features of the START model, DBHDS has established planning workgroups to create a comprehensive, coordinated, and more flexible crisis response system for individuals with ID or DD. Regional REACH programs will continue to be evidence-based and to meet expectations set forth in the DOJ Settlement Agreement. UNHC/START consultants are providing technical assistance to DBHDS to develop standards and performance measures as well as to provide regional training for REACH until the end of its contract (June 30, 2014). The DBHDS planning report, *Developmental Disabilities Crisis Response System: A Road Map to Creating a Community Infrastructure*, is online at <http://www.dbhds.virginia.gov/documents/ODS/DD%20Crisis%20Response%20System%20Plan%201%206%2014.pdf>.

Released in June of 2014, the fourth quarterly report by the court's Independent Reviewer (covering October 7, 2013 through April 6, 2014) complimented the Commonwealth on its compliance with many Settlement Agreement requirements. Noteworthy accomplishments that the report recognized included the following:

- Virginia funded and assigned more than the minimum required Medicaid Waiver slots for individuals with ID and DD on the Medicaid ID and DD Waiver Wait Lists;
- the number of individuals who transitioned to community settings from Training Centers, including a "well organized and effectively implemented" discharge planning and transition process;
- implementation of the mobile crisis teams for crisis support and stabilization services with trained staff in all five regions; and
- expanded case management services and licensure oversight.

However, the Independent Reviewer also cited the following areas of significant non-compliance with the Agreement:

- Case reviews of individuals with histories of challenging behaviors who lived in Region IV (Richmond metro area) or Region V (Tidewater) were conducted. The reviews found that language assessments were not offered to individuals for whom communication aids might reduce disruptive behaviors. For other individuals, recommendations for needed assessments were not made. When behavioral supports were provided, they lacked critical features, specifically, a Functional Behavioral Analysis, skill acquisition objectives, and data collection for measuring progress.

- Crisis intervention services for youth have not been developed. Current regional plans each lack 1 or more program components required by the Agreement, such as in-home services, mobile crisis response, and short-term alternatives to institutionalization. According to available DBHDS data, 4 of the 5 regions may not be offering in-home, crisis support for up to 3 days.
- Few individuals with a developmental disability (DD) other than intellectual disability (ID) used crisis services, and there existed no plan for outreach to individuals with DD and their families.
- Virginia has not implemented plans to facilitate the transition of children with ID and DD from nursing facilities and large intermediate care facilities for individuals with ID (ICFs/IID) to community homes.
- Providers rarely offered individuals who were not employed opportunities for integrated day activities. The Reviewer found the DBHDS implementation plan to expand day activities, which DBHDS labeled “preliminary,” to “lack specificity and depth about how to achieve those goals” and to delay actual creation of activities for another 2 years.

The Independent Reviewer stated that making progress in areas of non-compliance would require not only **increased resources** and expertise but also continued **expansion of inter-agency collaboration and problem solving**.

In 2013 DBHDS created and initiated the **Individual and Family Support Program (IFSP)** to help individuals on the Medicaid ID or DD Waiver Wait Lists to access needed services and supports that will enable them to remain in their own or family homes, including assisted living facilities (ALFs). Funded entirely through State appropriations, the IFSP can support up to 1,000 individuals statewide annually through 2021. The maximum funding level for any individual’s request is \$3,000 for the year. Each September, DBHDS announced the application period. Funding requests were processed on a first-come, first-served basis until program funds were fully committed. Due to the large volume of applications, DBHDS typically ended the application period within 1 to 2 months. Family members or caregivers of eligible individuals may apply for IFSP funds.

During state fiscal year (SFY) 2013, 825 individuals received funding for services under the IFSP, which averaged \$1,800 per person. As of February 20, 2014, that number had risen to 1,293 individuals. (At the time of this assessment, the SFY 2014 average per person funding was not available.) According to DBHDS, these were the most common purposes for which IFSP funds were used in both years:

- respite care;
- specialized therapies (speech, physical and occupational therapy, applied behavioral analysis, vision, water, and hippo [equestrian]);
- environmental modifications; and

➤ assistive technology.

To better align the IFSP with the intended goal of institutional diversion per the Settlement Agreement, DBHDS is reviewing the purchases made thus far and is considering further clarification of the types of services or supports to be funded prior to the September 2015 application period. Detailed information on IFSP eligibility and procedures is described in state regulation (12 VAC 35-230 et seq.) and in various documents available online at <http://www.dbhds.virginia.gov/ODS-IFSP.htm>.

In November of 2013, responsibility for daily operations for the **Medicaid Individual and Family Developmental Disabilities Support Waiver (DD Waiver)** transferred from the state Department of Medical Assistance Services (DMAS) to DBHDS. As required by federal law, DMAS will retain oversight responsibility for: paying DD Waiver provider claims; contract monitoring of the prior authorization process; handling appeals; and ensuring compliance of all policies and regulations with federal regulations. DMAS and DBHDS will jointly develop the DD Waiver budget, funding priorities and provider rates. All other operational tasks will be done by DBHDS. A full list of administrative tasks roles is provided in the announcement letter available at both the DMAS and DBHDS website.

At the present time, DBHDS is limited in its responsibilities for services to Virginians with a developmental disability (DD) other than an intellectual disability (ID). Under Code of Virginia § 37.2-203, DBHDS has responsibility

to ensure the development of long-range programs and plans for mental health, developmental, and substance abuse services provided by the Department, community services boards, and behavioral health authorities.

However, by statute (Code of Virginia § 37.2-100), “developmental services” are still defined as being those provided only to individuals with an intellectual disability. In addition, the state legislature has neither provided a regulatory mandate nor funding for DBHDS to provide services to Virginians with other types of developmental disabilities.

With respect to other state agencies with a mandate to serve individuals with disabilities, as a result of Governor McDonnell’s Government Reform initiative, the 2010 General Assembly approved the **consolidation** of two agencies and several programs: the Virginia Department for Aging (VDA); the Department of Rehabilitative Services (DRS); Adult Protective Services and Adult Services divisions from the Virginia Department of Social Services; and the state Long-term Care Ombudsman program. To allow for appropriate operational and programmatic planning, the consolidation occurred in stages over a 2-year period. Prior to the consolidation, each entity’s staff engaged in extensive cross training about their roles and functions as well as in strategic planning to improve services across the lifespan. On July 1, 2012, as authorized by Code of Virginia § 51.5-116 et seq., the **Department for Aging and Rehabilitative Services (DARS)** was implemented, in which VDA was renamed as the “**Virginia Division for the Aging.**”

The Adult Protective Services, Adult Services Divisions, and the Ombudsman program were incorporated into DARS effective July 1, 2013.

Although core responsibilities of each entity did not change, new responsibilities related to aging services and adult services were added to the powers and duties of the DARS commissioner (Code of Virginia, 51.5-131). The new DARS mission, which is detailed online at <http://www.vadrs.org/downloads/DARS2014E-flier.pdf>, is as follows:

In collaboration with community partners, provides and advocates for resources and services to improve the employment, quality of life, security, and independence of older Virginians, Virginians with disabilities, and their families.

Under state statute (Code of Virginia § 51.5-137), DARS has administrative responsibilities for long-term care services for the elderly to

develop appropriate fiscal and administrative controls over public long-term care services in the Commonwealth.

Enabling legislation (Code of Virginia § 51.5-143) additionally gave DARS statutory responsibility for publicizing and distributing guidelines on universal design and visitability features

to make structures and dwellings accessible for older Virginians and people who develop mobility impairment.

A new oversight resource for all state-funded services is the **Office of the State Inspector General (OSIG)**, which was created by the legislature in 2012 (Code of Virginia § 2.2-307 et seq.). With the Office, the legislation also created the new position of State **Inspector General (IG)**. The OSIG incorporates the inspector general offices for these state Departments:

- Behavioral Health and Developmental Services,
- Corrections,
- Juvenile Justice,
- Transportation, and the
- State Internal Auditor.

All functions and duties of each Department's IG will continue under the new agency. The OSIG is charged to investigate complaints alleging fraud, waste, abuse or corruption by a state agency or a non-state agency (those supported entirely or principally by state funds).

Authorizing legislation empowers the OSIG to investigate the management and operations of state and specified, non-state agencies as well as to conduct performance reviews. The OSIG must provide semi-annual reports to the General Assembly and the Governor regarding its investigative and monitoring activities, which are posted on its website at

<http://www.osig.virginia.gov>. The Governor may request a special OSIG investigation to address a significant event (e.g., Virginia Tech shootings) or information regarding state agency services or operations. Parts or all of an investigative report may not be made public, however, due to: executive privilege; the privacy rights of individuals served or their caregivers; or pending legal action. The State Inspector General is appointed by the Governor, subject to confirmation by the legislature, for a four-year term. By statute, the SIG must have experience or expertise in accounting, public administration or audit investigations.

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 or private nonprofit and for-profit service providers across the State adds to this complexity.

A description of all community-based programs and supports available to individuals with developmental and other disabilities is beyond this *Assessment*. The community supports covered here are organized by the following key programs and services and listed by their sections in this chapter:

- B. Assistive Technology and Related Services**
- C. Brain Injury Services**
- D. Spinal Cord Injury Services**
- E. Community Rehabilitation Case Management Services**
- F. Comprehensive Services Act for At-risk Youth and Families**
- G. Centers for Independent Living and Related Services**
- H. Independent Living Services for the Blind and Vision Impaired**
- I. Intellectual Disability Services (Non-Medicaid Waiver)**
- J. Interpreter and Other Services for the Deaf and Hard-of-Hearing**
- K. Omnibus Budget Reconciliation Act Services**
- L. Personal Assistance Services (Non-Medicaid Waiver)**
- M. Services for the Elderly Population**

Interested readers can find additional information on various state websites. Extensive funding information on state agency programs can be found in the state appropriations bill and other documents available through the Department of Planning and Budget's (DPB) website (<http://www.dpb.virginia.gov>). Additional information about services provided and performance goals for various programs are found in agency biennium strategic plans posted on the Virginia Performs website (<http://www.vaperforms.virginia.gov>). 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*.

B. Assistive Technology and Related Services

As defined by State regulation (22 VAC 30-20-10), **assistive technology (AT)** is

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.

AT devices range from “reachers” and other simple, mechanical aids to devices as complex as electric wheelchairs that respond to breath controls or adaptive environmental controls that respond to voice commands. AT services are defined as

any service that directly assists an individual with a disability in the selection, acquisition or use of an AT device.

These services may include the following:

- needs and functional evaluations of an individual in his or her natural environment;
- purchasing, leasing or otherwise providing for AT devices;
- selecting, designing, customizing, adapting, maintaining, repairing, or replacing AT;
- coordinating and using other therapies, interventions, or services with AT devices, such as education and rehabilitation programs;
- 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.

1. Screening and Eligibility for AT Services

State-funded AT services are available through 3 state disability service agencies. The largest of these, the **Department for Aging and Rehabilitative Services (DARS)**, serves individuals with disabilities of all ages and levels of ability with two AT programs:

- **Virginia Assistive Technology System (VATS)**. Eligibility information is available online at <http://www.vats.org> or by phone (800-552-2435 or 552-8490). VATS provides an array of AT services and technologies to enable Virginians to participate more actively in their communities. One of their services is a reuse program for durable medical equipment. Gently used, donated equipment may be available through the **Virginia Reuse Network (VRN)**, which is coordinated by VATS and is online at

<http://www.vats.org/atrecycling.htm>. VRN prioritizes individuals with disabilities who lack resources to purchase AT equipment on their own.

- **Woodrow Wilson Rehabilitation Center (WWRC)**. Located in Fishersville, WWRC provides AT through outpatient clinics and residential programs. Priority is given to current DARS clients who need AT to obtain or keep a job; therefore, eligibility criteria follow any Vocational Rehabilitation Order of Selection category in effect. Detailed eligibility information for outpatient and residential services is available on WWRC's website at <http://www.wwrc.virginia.gov/admissions.htm> or by contacting WWRC by phone [800-345-9972, Ext. 7065; or 540-332-7065; or (for TTY) 800-811-7893].

Another source of AT and related services is the **Virginia Department for the Deaf and Hard of Hearing (VDDHH)**, which serves individuals who are deaf, hard of hearing, deafblind or otherwise both hearing and vision impaired. VDDHH's two AT programs currently are the **Technology Assistance Program (TAP)** and **Virginia Relay**. TAP provides telecommunication equipment to qualified applicants whose impairments prevent them from using a standard phone. Since October of 2012, VDDHH revised TAP eligibility guidelines to increase services to Virginians who are veterans and have a hearing or speech loss. Eligibility information and an application form for TAP services is available online at <http://www.vddhh.virginia.gov/TechIntro.htm> or at one of the local VDDHH outreach offices listed at <http://www.vddhh.org/orproviders.aspx>; or by phone [(800) 552-7917 (V/TTY)].

Virginia Relay, a federally mandated service, provides traditional and captioned telephone relay services to persons who are deaf, hard-of-hearing, deafblind, or speech impaired. Relay services, which are available all day, year-round, enable individuals to communicate with standard telephone users with the strictest confidentiality.

For individuals needing assistance, VDDHH staff and local **outreach contractors** provide information and referral on available services as well as topics related to hearing loss and deafness, and they collaborate with the TAP and Virginia Relay Services to help them obtain needed assistive technology. VDDHH additionally conducts outreach to provide information and training for state and local agencies (including public safety), businesses, and civic organizations. VDDHH outreach staff and local contractors provide education and awareness on topics such as sign language skills, using interpreters effectively, obtaining assistive technology, and coping with hearing loss. In SFY 2013, outreach was provided to 31,820 individuals statewide.

When an individual has been denied **interpreter services** by private providers or other organizations covered by the Americans with Disabilities Act (ADA), VDDHH encourages the individual to have the entity contact them directly for additional information and assistance in locating a qualified interpreter. While the agency does not have enforcement authority for the ADA, VDDHH staff will discuss options with the entity for effective communication, including fact sheets.

2. Access to and Available AT and Related Services

AT 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 AT provider or agency has its own eligibility criteria and procedures for: service access and delivery; scope and duration of service provided; mediation or appeals; and user fees, if any. An individual with a disability may have access to AT through multiple programs at different times based on evolving needs and eligibility criteria.

The Department for Aging and Rehabilitative Services’ (DARS’) **Virginia Assistive Technology System (VATS)** provides services through its central office in Richmond and three regional sites:

1. Southwest VATS at Virginia Tech in Blacksburg,
2. Southeast VATS at Old Dominion University in Norfolk, and
3. Northern VATS at George Mason University in Fairfax.

Available AT devices, services, and funding sources vary among the 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 AT, staff at the sites can provide more detailed guidance about the application and benefits of specific devices or services. The AT devices most frequently demonstrated or loaned by VATS are iPod Touch with applications for cognition and communication and Livescribe Smart Pens.

Table 38 describes the number of services provided by VATS during state fiscal years (SFYs) 2010 and 2013. Note that between these years, the number of short-term AT equipment loans and demonstrations increased while the number of trainings, informational, and other types of assistance declined.

Table 38. Assistive Technology Services Provided by VATS in SFYs 2010 and 2013		
VATS Services Provided	2010	2013
AT Short-term equipment loans made	51	144
AT demonstrations conducted	128	145
AT trainings conducted	2,098	1,837
Information or other assistance provided	2,096	318

Source: Department for Aging and Rehabilitative Services.

VATS staff attributes the shift in service utilization to changes in the federal law (Assistive Technology Act) and federal program requirements. A larger percentage of funding was mandated for state-level activities such as the AT equipment loans and demonstrations rather

than trainings and outreach. In addition, over the past five years, significant technological improvements have occurred and been made available to meet the AT needs of individuals with disabilities, including:

- the introduction of smart phones,
- tablet computing with touch screens, and
- a growing selection of applications that assist people with disabilities.

Table 39 lists the total number of unduplicated individuals who received some type of AT service through VATS for SFYs 2009 through 2013. Over this period, the number of people served by VATS steadily declined, decreasing by 4,981 individuals, or 58.4 percent. DARS staff attributes the decrease to several factors: loss of Goodwill Industries as a reuse partner in 2009; the loss of dedicated federal funding for AT reuse programs; and changes in service priorities in compliance with the current federal AT Act.

Table 39. Individuals receiving Assistive Technology Services through VATS in SFYs 2009–2013					
State Fiscal Year	2009	2010	2011	2012	2013
Total (unduplicated) persons served	8,534	5,914	6,511	4,786	3,553

Grant funds in SFY 2010 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 individuals with disabilities. Local public and private partners supply VRN with volunteers and generate donations of gently used rehabilitation equipment as well as funds. Donated equipment is sanitized, repaired or refurbished, and distributed through regional recycling centers listed at <http://www.vats.org/atrecycling.htm>. **Table 40** provides the number of individuals who received recycled AT equipment through the VRN since SFY 2009.

Table 40. Individuals receiving Recycled Assistive Technology Equipment from the VRN by SFY					
State Fiscal Year	2009	2010	2011	2012	2013
Number of individuals	2,534	502	603	696	966
Amount change from prior SFY		- 2,032	+ 101	+ 93	+ 270
Percent change from prior SFY		- 80.2%	+ 20.1%	+ 15.4%	+ 38.8%

Source: Department for Aging and Rehabilitative Services.

As noted above, there was a significant decline in the number of individuals receiving reused AT from VRN. After a low of 502 individuals in SFY 2010, however, the number of AT equipment recipients increased each year but has not achieved the level of SFY 2009. DARS

reports that the most frequent VRN requests are for recycled durable medical equipment, specifically manual wheelchairs, tub benches, walkers, and bariatric equipment.

DARS' Woodrow Wilson Rehabilitation Center (WWRC) provides comprehensive AT assessments and customized technology services through a variety of outpatient and residential clinics and programs. Policies and procedures vary among the programs, some of which serve specific disabilities. WWRC program teams may include rehabilitation and computer systems engineers, physical and occupational therapists, speech/language pathologists, and social workers, as needed. WWRC also provides the specialized training in AT use critical to successful daily independent functioning. For example, its 10-day, intensive residential **Empowerment through Communication (ETC)** program assists individuals in improving their communicative competence using **alternative/augmentative communications (AAC) devices**.

In SFY 2013, **WWRC residential services** increased its bed capacity. As a result, the average daily census increased 7.2 percent, from 290 in SFY 2012 to 311 in SFY 2013; the number of cases increased 3.7 percent (96 cases) from 2,613 in SFY 2012 to 2,706 in SFY 2013. In addition to providing AT to inpatients, **WWRC outpatient programs** provide a variety of AT services for eligible adolescents and adults with disabilities, including the following:

- 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.

Table 41 below shows the number of individuals receiving AT services through WWRC programs for SFYs 2011 through 2013.

Table 41. Individuals receiving Assistive Technology Services by WWRC Program for SFYs 2012–2013			
State Fiscal Year	2011	2012	2013
Residential program	74	79	73
Outpatient program	429	313	321

Source: Department for Aging and Rehabilitative Services.

Due to its bed capacity, the WWRC residential programs provided AT services to a relatively stable number of persons during that time. The number served in WWRC outpatient clinics,

however, declined by 27 percent between SFYs 2011 and 2012 due to budget cuts since 2010. The numbers increased slightly in SFY 2013.

Individuals seeking information/referral or technical assistance services from the Virginia Department for the Deaf and Hard of Hearing’s (VDDHH) **Technology Assistance Program (TAP)** may contact either VDDHH or one of its local **Loan-To-Own (L2O)** providers. TAP provides equipment to qualified individuals through its L2O programs, which distribute TTYs, captioning telephones, amplified phones and handheld devices, signalers, and speech amplifiers as well as specially requested equipment for persons with both a hearing and vision loss. Eligible applicants are served on a first-come, first-served basis based on available funds. In times of fiscal restraint, VDDHH may give priority to new applicants or to recipients who have not received AT equipment in the previous 4 years and who do not have functioning equipment as verified by VDDHH or a vendor. Financial eligibility for TAP devices is based on incomes at or below 250 percent of the Federal Poverty Level (FPL). Service fees are determined by a sliding scale.

Through **TAP L2O**, a qualified individual with hearing loss has the opportunity to test various technologies and AT devices designed to enhance independence and quality of life. 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 the individual’s needs, he or she may exchange it for a different device to test in the home or workplace for an additional 30 days. TAP may provide more than one AT device to an individual based on needs. All devices carry a 1-year warranty, and qualified TAP participants can apply for new equipment every 4 years. Since SFY 2010, the TAP L2O program has been fully operational online with an electronic application submission system and a decentralized equipment inventory. Outreach Specialists now deliver the equipment to qualified applicants to test and install, reducing the waiting time for receipt of equipment from 4 to 6 weeks, to same day. **Table 42** provides utilization data for select SFYs between 2007 and 2013.

Table 42. TAP Loan-To-Own Assistive Technology Program Use by SFY				
State Fiscal Year	2007	2011	2012	2013
Number served	523	1,098	1,174	1,538
AT devices distributed	n/a	1,318	1,836	2,018

Source: Virginia Department for the Deaf and Hard of Hearing.

As the data indicate, the number of individuals receiving AT services through TAP more than doubled between SFYs 2007 and 2011, with an increase of 31 percent between 2012 and 2013. The number of distributed AT devices increased by 53.1 percent between SFYs 2011 and 2013, with the largest increase between 2011 and 2012. These increases resulted from several factors: efficiencies realized by implementation of a L2O database, decentralization of equipment inventory, and implementation of the TAP Veterans program.

Administered by VDDHH, the **Virginia Relay** telecommunications service for individuals with hearing or speech loss can be accessed by dialing 7-1-1 on any phone. Virginia Relay provides an intermediary communications assistant who confidentially relays text messages created on a Teletype (TTY) or similar device-to-voice (and vice versa) equipment. Special features are available for individuals who are speech-disabled, are Spanish speaking, or use American Sign Language (ASL). Relay users are encouraged to complete a Relay Choice Profile that automatically notifies the communications assistant of the person's calling preferences. By law, the communications assistants must maintain strict confidentiality.

Use of TTY-based relay services has declined in Virginia from 1.4 millions calls in SFY 2004 to less than 350,000 in SFY 2014, a 75 percent decrease. This trend is directly attributable to the availability of alternative Internet and wireless relay services that allow individuals to communicate directly using text messaging, video relay, captioned phone services, and other technologies. With newer technology such as the captioned telephone (**CapTel**) service, Virginia Relay can transmit both voice and text for hard-of-hearing or late-deafened adults. Also growing in use has been **Video Relay Service (VRS)**, which enables sign language users to communicate in their native sign language using a special video device. VDDHH outreach providers across the State can provide information, demonstrate the use of CapTel and videophones, and provide technical assistance for these services.

These newer relay technologies are not without challenges. Video Relay Services (VRS) have remained unavailable in rural areas where broadband or DSL infrastructure does not exist; and where available, its use is often blocked by a business' Internet security firewall. CapTel services are often not compatible with VoIP or server-based phone services used by public and private entities. Also, much of the equipment available to state equipment distribution programs such as TAP are analog based and may not be compatible with newer, wireless home phone services.

In October of 2013, AT&T, the Commonwealth's current relay contractor, announced it would exit the relay industry during the summer of 2015. This exit will require VDDHH to issue a Request for Proposal for a new relay provider effective August 1, 2015, the ending date of the current contract with AT&T. Recent modification of VDDHH's relay budget language by the 2014 General Assembly is expected to result in significant cost savings with the new contract.

VDDHH additionally provides **outreach services** through its Resource Centers at locations statewide: Richmond, serving central Virginia; Fredericksburg area; Fairfax County area; Eastern Shore; Southwest/Western area (Abingdon, Roanoke, New River Valley, Lynchburg, and Staunton); Norton/Grundy area; and Norfolk/Hampton Roads areas. For referral to an outreach provider, either contact VDDHH directly by phone or by e-mail (frontdsk@vdhh.virginia.gov). VDDHH Outreach services include training, technical assistance, and information/referral on AT and other services to Virginians with hearing impairments to enhance independent living, and to caregivers, service providers, public safety officials, and business professionals to improve communication.

The total number of outreach contacts has decreased significantly over time.

- SFY 2007 had 71,141 contacts;
- SFY 2010 had 37,779 contacts; and
- SFY 2012 had 28,484 contacts.

Between SFYs 2007 and 2010, a significant decrease in contacts (46.9 percent) occurred, primarily because of a 30-percent cut in state funds for outreach. The VDDHH Resource Library was closed due to both budget reductions and declining circulation. At this time, most of the VDDHH Outreach staff works part time and schedules small-group appointments to conserve limited resources.

In 2011, through a competitive application process, the VDDHH was selected as the certified entity statewide to receive federal funding for participation in a pilot program, the **National Deaf-Blind Equipment Distribution Program** (also referred to as the “iCanConnect” program). This national pilot program, which was mandated by Section 105 of the 21st Century Communications and Video Accessibility Act, is to enable access to modern telecommunication tools and technology by low-income individuals who have both a hearing and vision loss. Federal grants in each state are to support local activities (outreach, assessments, equipment installation and maintenance, and training) as needed for the target population at no cost, so they can engage fully in society. Based on a federal formula, VDDHH received an annual award of \$226,000 to provide this service to qualified individuals. In collaboration with the state Department for the Blind and Visually Impaired (DBVI) and the Helen Keller National Center Office at Virginia Commonwealth University, VDDHH began services in 2012; the grant is funded through June of 2015.

3. Cost and Payment for AT and Related Services

For individuals, AT equipment and services may be paid for in one of several ways. Private insurance carriers as well as public insurance (Medicaid or Medicare) may cover AT costs. Some state agency programs directly provide AT or services to individuals who are uninsured or under-insured or have needs exceeding their available resources at no cost or on a sliding fee scale. Funding sources for each AT programs administered by a state agency typically include some combination of federal and state government monies as well as foundation grants and user fees (when applicable) or insurance co-payments.

As noted earlier, the **Department for the Aging and Rehabilitative Services (DARS)** administers the Virginia Assistive Technology System (VATS), the Virginia Reuse Network (VRN), and the Woodrow Wilson Rehabilitation Center (WWRC). Federal monies primarily fund DARS itself. In SFY 2012, only 17 percent of its total annual budget was from state General Funds. An exception, however, is DARS Community-based Services Division, which receives over 60 percent of its annual budget from state General Funds. DARS distributes federal and state fund appropriations to each of its programs based on the respective legislative mandate.

Table 43 shows the total expenditures across state fiscal years (SFY) for **VATS** and **VRN**, both of which obtain additional funds from other sources. VATS regularly seeks grant funds

from foundations as well as government sources. The VRN pools money and in-kind services from its partners who assist in soliciting donations of funds and used AT equipment.

Program	2009	2010	2011	2012	2013
VATS	\$785,715	\$605,673	\$604,865	\$604,472	\$574,644
VRN	N/A	\$75,000	\$75,000	\$75,000	\$126,000

Source: Department for Aging and Rehabilitative Services.

WWRC, which provides AT services both to vocational residents and clinic outpatients, does not track expenditures by type of service. WWRC's funding is discussed in more detail in the **Employment** chapter of this *Assessment*.

In its *2013 Agency Strategic Plan Executive Progress Report*, the Virginia **Department for the Deaf and Hard of Hearing (VDDHH)** notes that its primary source of funding is special revenues, which comprised 92 percent of its annual budget in SFY 2013 and almost 93 percent in SFY 2014. Total VDDHH appropriations for SFYs 2013 and 2014 are listed in **Table 44**.

Source	2013	2014
State General Fund	\$844,985	\$844,994
Federal, Special Funds	\$10,561,124	\$10,938,174

Special Funds include designated revenues from the Communications Sales and Use tax, which became effective in January 2007. This tax is collected by the state Department of Taxation, on all phone landlines, wireless, Internet, cable and satellite services in Virginia. The tax revenues support VDDHH's TAP, Virginia Relay, and associated administrative services. Federal regulations mandate provision of Virginia Relay services, related equipment distribution program, and oversight.

Total expenditures for the Technical Assistance Program (TAP) and Virginia Relay are listed by state fiscal year in **Table 45**.

Program/Service	2007	2010	2011	2012	2013
TAP	\$381,540	\$410,069	\$397,692	\$374,986	\$432,399

Program/Service	2007	2010	2011	2012	2013
Virginia Relay	\$14,364,229	\$10,226,176	\$8,632,713	\$9,133,989	\$8,729,488

Source: Virginia Department for the Deaf and Hard of Hearing.

While there is no cost to use the Virginia Relay service, individuals must still pay the usual long-distance call/service fees of their telecommunications provider.

Some Virginians with disabilities who need AT equipment do not have insurance coverage or are not eligible for conventional loans. They may obtain financial assistance for AT through the **Assistive Technology Loan Fund Authority (ATLFA)**, a State Authority created with public funds. The ATLFA provides affordable financing alternatives (such as no down payments and longer repayment terms) to help make adaptive equipment a possibility for those individuals. Regardless of income, any Virginia resident with a disability or a caregiver of a person of any age with a disability can apply for a loan. Credit history, income, and debts are considered in loan approval; special consideration is given to disability and medically related credit issues. Any type of equipment can be financed as long as it relates to an individual’s disability such as vision aids, communication devices, hearing devices, and home or vehicle modifications. Loans for home-based businesses are limited to business-related equipment, inventory, or supplies.

Individuals who meet the ATLFA lending criteria can borrow up to \$30,000 (with no minimum amount) at a 5-percent interest rate for equipment and older vehicles. The interest rates for new vehicles or vehicles no more than 2 years old (based on the current model year) are indexed quarterly by the Board of Directors. Exceptions are made on a case-by- case basis for direct loans greater than \$30,000. ATLFA no longer guarantees loans to a bank. Its former partner, SunTrust Bank, decided to terminate its business agreements with all alternative financing programs nationwide. Beginning in January of 2014, the ATLFA became a direct lender with no banking partner; and all loan requests are processed and closed directly by the Authority. To apply for a loan, call 1-866-835-5976 or obtain a loan application form online at <http://www.atlfa.org>.

Over the past seven years, ATLFA has received and processed over 200 loan applications annually. Typically, half or more of the loan applications are approved. Since SFY 2006, the lowest loan approval rates occurred during the recession: 45.3 percent in SFY 2007 and 43.4 percent in SFY 2009. In SFY 2010, ATLFA processed 231 loan requests, of which 50.2 percent were approved. In SFY 2011, 251 were processed and 54.5 percent were approved. In SFY 2012, 209 were processed and 51.6 percent were approved, and in SFY 2013, 226 were processed and 55.7 percent were approved.

Table 46 shows the number of loans approved by ATLFA during SFYs 2009 through 2013 for each loan category. Loans made through SunTrust Bank may be guaranteed by ATLFA or non-guaranteed. Direct loans are those made and managed by ATLFA.

Table 46. ATLFA Loans Provided for Assistive Technology by SFY					
Types of Loans Approved	2009	2010	2011	2012	2013
Direct loans	74	92	101	88	114
Non-guaranteed loans	6	15	24	11	12
Guaranteed loans	9	9	12	9	0

Source: Assistive Technology Loan Fund Authority.

As the data indicate, the majority of ATLFA loans over time have been direct loans, which have increased as a proportion of total approved loans. Since SFY 2006, in fact, the proportion of direct loans has dramatically increased: in SFY 2006, they were 59.1 percent of all loans approved. By SFY 2010, they were 79.3 percent, and, in SFY 2013, they represented 90 percent of all approved loans.

ATLFA annual funding is comprised entirely of federal monies provided through the federal Rehabilitation Services Administration (RSA). Loan issuances for AT equipment through ATLFA loans have been as shown in **Table 47**.

Table 47. Total ATLFA Funds Loaned for Assistive Technology by SFY					
State Fiscal Year	2009	2010	2011	2012	2013
Loan Issuances	\$1,052,140	\$1,045,062	\$1,059,278	\$1,033,952	\$1,447,999

During SFY 2013, these were most commonly purchased AT services with ATLFA loans:

- adapted or modified vehicles (72 loans),
- hearing or communication devices (16), and
- home/environmental modifications (12).

This pattern of purchases has been consistent for a number of years.

Oversight for the Assistive Technology Loan Fund Authority (ATLFA) is provided by a Board of Directors whose role and membership is set in Code of Virginia § 51.5-55. The Board members include the state Secretary of Health and Human Resources (or designee), an employee of the Woodrow Wilson Rehabilitation Center (WWRC), an experienced consumer lender, a certified public accountant, two individuals with investment finance experience, and six individuals with disabilities. In addition to ATLFA's statutory responsibilities, policies and procedures for consistent delivery of the loan program are set forth in the *Alternative Financing Program Manual*, the *Telemark Loan Manual*, and ATLFA's *Governance Manual* and bylaws, which are approved by the ATLFA Board. The ATLFA also complies with reporting requirements

of the federal Rehabilitation Services Administration (RSA) grant, which is a funding source: ATLFA submits an annual report describing program activities, both the types and amounts of loans issued, and the demographic characteristics of loan applicants. The state auditor of public accounts audits ATLFA's fiscal records and accounts of loans as well as any loan fund or loan guarantee fund that the Authority administers or manages. The most recent routine audit (2012) by the auditor of public accounts of the ATLFA reported that all transactions had been properly recorded and reported, and there were no internal control matters or instances of non-compliance that needed to be reported.

4. Monitoring and Evaluation of AT and Related Services

Administered by the Department for Aging and Rehabilitative Services (DARS), **Virginia Assistive Technology System (VATS)** and the **Virginia Reuse Network (VRN)** each are guided by the Department's three-year plan that must be submitted for approval to the **US Rehabilitation Services Administration (RSA)**, VATS' federal funding source. The RSA sets annual performance measures and targets for both VATS and VRN. Performance measures center on client self-reports from individuals with disabilities and others (family members, guardians, employers, various professionals) on their ability to access or acquire appropriate AT equipment through VATS, and used durable medical equipment (DME) through VRN.

Information is collected and compiled on a routine weekly, monthly, quarterly, and annual basis. VATS receives reports from its regional sites and the Virginia Reuse Network on:

- how many individuals received recycled AT devices;
- the retail value of AT received and the resulting cost savings; and,
- each quarter, a summary of evaluations from large training programs or conferences.

As part of VATS' annual program report to RSA, this information plus the results of client follow-up and satisfaction surveys are compiled at the state level and are compared to VATS' three-year plan. The state plan can be amended annually to reflect services offered and compliance with federal mandates. In SFY 2013, both VATS and VRN exceeded RSA performance goals, and both had high satisfaction ratings from individuals served.

AT services provided by the Durable Medical Equipment (DME) Program at DARS' **Woodrow Wilson Rehabilitation Center (WWRC)** are accredited by the national Accreditation Commission for Health Care (ACHC), which sets clinical, operational, and facility standards. The WWRC AT program routinely collects information on specific individual satisfaction measures by surveys and from calls to individuals who have received wheelchairs or other DME. Based on the customer feedback, therapists are assigned to contact those individuals for troubleshooting and other follow-up. All quality assurance information, which is tracked in a database, is reviewed by program managers semi-annually to determine ways to improve service delivery and further reviewed annually by the WWRC AT Center of Excellence Focus Group.

The **Department for the Deaf and Hard of Hearing's (VDDHH) Technology Assistance Program (TAP)** routinely conducts satisfaction surveys of its customers. Responses are routinely documented, and concerns are forwarded, as needed, to the appropriate outreach specialist, program coordinator, or the VDDHH director, who is responsible for quality assurance. Procedural changes in the TAP Loan-to-Own (L2O) program have significantly reduced the time required to receive equipment from up to 6 weeks to several days. The VDDHH agency strategic plan reports that customer feedback has approached 100 percent as "satisfied" or "very satisfied" with services received.

By state statute (Code of Virginia, § 56-484.7), VDDHH is responsible for managing and monitoring telecommunications contracts for all **Virginia Relay** services and for annual reports to the Federal Communications Commission (FCC) on contractor performance and consumer feedback, including a log of all consumer complaints. The FCC must certify that relay services meet federal standards. Virginia Relay service contracts include specific steps to ensure vendor compliance and to ensure responsiveness to individual complaints. User comments are compiled daily by Virginia Relay contractors and reported monthly to VDDHH. VDDHH oversight includes routine test calls by agency staff and by external, independent testers on contract, 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.

C. Brain Injury Services

How medical conditions or functional impairments are defined in state regulations and law impact service eligibility. Typically, state law adopts definitions as required by the federal law authorizing the funds for services to address a particular condition/impairment or category of impairments. Both the Virginia Administrative Code (12 VAC 35-46-10 and 12 VAC 35-105-20) and Code of Virginia (§ 37.2-403) define **brain injury (BI)** as

any injury to the brain that occurs after birth, but before age 65, that is acquired through traumatic or nontraumatic insults. Nontraumatic insults may include, but are not limited to, anoxia, hypoxia, aneurysm, toxic exposure, encephalopathy, surgical interventions, tumor, and stroke. Brain injury does not include hereditary, congenital, or degenerative brain disorders, or injuries induced by birth trauma.

Under Code of Virginia § 51.5-119, the Department for Aging and Rehabilitative Services (DARS) is Virginia's lead agency for planning, coordinating, and promoting rehabilitative services for individuals with "**significant physical or sensory disabilities.**" Legislation passed in 2014 (HB 1076), which became effective July 1, 2014, changed terminology in the Code of Virginia. The previous term of "functional and central nervous system disorders" was changed to "physical or sensory disability" under the amended § 51.5-116 but retains the same definition as the previous term:

a disability resulting in functional impairment or impairment of the central nervous system, which may include but is not limited to brain injury, spinal cord injury, cerebral palsy, arthritis, muscular dystrophy, multiple sclerosis, Prader-Willi syndrome, and systemic lupus erythematosus (lupus).

DARS administers brain injury services through two programs: the DARS **Brain Injury Services Coordination (BISC) Unit**, operated within the DARS Community Based Services Division; and the **Woodrow Wilson Rehabilitation Center (WWRC)** in Fishersville.

The DARS BISC Unit is composed of a director, a part-time program specialist, and a part-time administrative staff person. The following are included in the BISC Unit's responsibilities:

- Provide outreach, information, and referrals on available community services for persons with an acquired brain injury or neurotrauma, their family members and caretakers, and to other DARS personnel and external customers.

Administer contracts with private or nonprofit agencies to provide brain injury (BI) services and administer state or federal grants for brain injury services. (See the next section, **Screening and Eligibility for Brain Injury Services.**)

- Promote service quality and provide training for public and private providers of BI services as well as vocational rehabilitation field staff. In collaboration with DARS field staff, resolve concerns/complaints by customers regarding agency-funded BI services.

Administer the Brain Injury Direct Services (BIDS) Fund, which pays for short-term services for a small number of eligible individuals with acquired brain injury. (See the **Cost and Payment for Brain Injury Services** section below.)

- Administer a federal system change grant project, "Closing the Gap," provided through the Traumatic Brain Injury Implementation Partnership Act. Begun in 2009 and ending in June 2014, project activities included a comprehensive statewide needs assessment and implementation of BI assessment training for staff at residential facilities for youth in the Department of Juvenile Justice.
- Provide staff functions for the Virginia Brain Injury Council and manage the Commonwealth Neurotrauma Initiative Trust Fund, which supports clinical and other research.

1. Screening and Eligibility for Brain Injury Services

To be eligible for services through the DARS **Brain Injury Services Coordination (BISC) Unit**, an individual must have an acquired brain injury. Program information is available online at <http://www.vadrs.org/cbs/biscis.htm>.

Administered by DARS, the **Woodrow Wilson Rehabilitation Center (WWRC)** has specialized services targeting two populations: those who need **Brain Injury Services (BIS)** and individuals requiring **Spinal Cord Injury (SCI) Services**. (See the **Spinal Cord Injury Services**

section of this chapter for more information on the latter.) Available on a residential or outpatient basis, both programs give priority for services to DARS clients who are pursuing vocational goals. All applicants must be at least 16 years old. Individuals may self-refer by contacting the WWRC admissions office either by phone at (800) 345-9972, Ext. 7065 or online at AdmissionsInfo@wwrc.virginia.gov. Individuals also may seek admission through their local office of DARS. 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 levels and service needs.

As noted online (<http://www.wwrc.virginia.gov/braininjuryservices.htm>), the **WWRC Brain Injury Services** program treats individuals with either a traumatic or non-traumatic acquired brain injury who have demonstrated potential for rehabilitation or employment. To be eligible, an individual must be

medically, physically, and psychologically stable with a favorable prognosis for participating in, completing, and benefiting from the services.

Applicants with a co-occurring psychiatric diagnosis or a history of substance abuse must be able to demonstrate six consecutive months of stability.

2. Access to and Available Brain Injury Services

Services for persons with brain injuries encompass a wide array and are designed to facilitate community reintegration and personal independence to the maximum extent possible. The DARS' **Brain Injury Services Coordination (BISC) Unit** manages specialized brain injury (BI) services offered in communities through contractual agreements. During SFY 2013, BISC had contracts with 10 provider organizations that operated 13 BI programs statewide. Three core BI services have been a funding priority by DARS:

1. comprehensive case management, which includes needs assessment, service referral/coordination, and service monitoring;
2. clubhouse or day programs to improve social/behavioral skills, independent living skills, and employability; and
3. regional resource coordination, which provides public education/awareness, outreach, and provider recruitment.

A full list of available brain injury (BI) services by geographic area is provided in the DARS *Annual Report to the General Assembly on Brain Injury and Spinal Cord Injury Services*. This report identifies the providers in each area as well as funding levels and services provided by each. It is available online at [http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/RD842014/\\$file/RD84.pdf](http://leg2.state.va.us/dls/h&sdocs.nsf/By+Year/RD842014/$file/RD84.pdf).

The DARS BISC Unit has a collaborative relationship with the **Woodrow Wilson Rehabilitation Center's (WWRC) Brain Injury Services (BIS)** 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.

WWRC Brain Injury Services has experienced, interdisciplinary teams, comprised of WWRC staff and community partners, to provide medical rehabilitation as well as vocational assessment and training, and treatment planning. All services emphasize development or improvement of (1) self-sufficiency, (2) personal responsibility, and (3) vocational preparation. Assessments and services may include the following based on individual needs:

- home and work accessibility;
- assistive technology;
- independent living skills;
- driving skills;
- physical, occupational, and speech/language therapy; and
- neuro-psychological testing and psychiatry consultation.

The BIS staff may also refer an individual to the **WWRC Life Skills Transition Program**, which is a comprehensive educational opportunity to develop interpersonal skills, independent living, and basic workplace literacy, among others as indicated. **WWRC's Brain Injury Clinic** is a one-day outpatient service consisting of neuropsychological and physical medicine evaluations.

As noted earlier, DARS develops and publishes an annual report to the General Assembly on brain injury services delivered during the state fiscal year (SFY). Using data from the most recent annual report, the list below highlights the number of individuals with BI who received direct services in SFY 2013 by provider and program. Please refer to the DARS annual report for details on other BI services (training, awareness/outreach) delivered by these providers. Some counts may be duplicative for each program because an individual may participate in or receive more than one service during the year.

- **Brain Injury Association of Virginia or BIAV (statewide):** The DARS BISC Unit funds BIAV to implement the Virginia Statewide Trauma Registry Outreach Program. This outreach provides newly injured Virginians with information on BI and available resources by mail.
 - Consultations and information/referral, 828 individuals
 - Support groups, 112 with 631 participants
- **Brain Injury Services, Inc. (northern Virginia area):**
 - Adults
 - Westwood Clubhouse (Fredericksburg), 18 members
 - ADAPT Clubhouse, 48 members

- Adult case management, 352 individuals
- Children
 - Pediatric case management, 65 children
 - Consultations, 50 children
 - Support groups, 11 with 150 participants
- **Brain Injury Services of Southwest Virginia (BISSWVA):**
 - Case management, 266 individuals
 - Consultations, 115 individuals
 - Life skills services, 25 individuals
- **Community Futures Foundation (Tidewater and Richmond areas):**
 - Tidewater area - Denbigh House
 - Members, 58 (with an average daily census of 15)
 - Consultations, 9 individuals
 - Richmond area - The Mill House
 - Members, 60 (with an average daily census of 17)
 - Consultations, 50
 - Case management, 73 individuals with 28 consultations
- **Crossroads to Brain Injury Recovery or CBIR (Greater Shenandoah Valley area):**
 - Case management, 72 individuals
 - Consultations 73
- **Eggleston Services (Tidewater area):**
 - Beacon House
 - Members, 42 (with an average daily census of 16)
 - Consultations, 8
- **MWS-Brain Injury Services of MARC Workshop, Inc. (Danville/Martinsville area):**
 - Case management, 39 individuals
 - Support groups, 12 (no attendee counts)
- **Virginia NeuroCare, Inc., (Region 10):**
 - High Street Clubhouse
 - Members, 17 (with an average daily census of 16)
 - Consultations, 4 individuals

- **No Limits Eastern Shore or NLES:**
 - No Limits Day Program
 - Members, 27 (with an average daily census of 12)
 - Consultations, 4
- **Virginia Supportive Housing or VSH:**
 - Case management, 25 individuals

In addition to direct services to individuals, the DARS BISC Unit reports that each program conducts professional training on the evaluation and treatment of brain injuries in its region or locality and provides BI outreach and education to individuals, family members and caregivers. **Table 48** lists the total number of individuals who received any type of service (including training and outreach) from the BI contractors in state fiscal years (SFYs) 2009 through 2013. Between SFYs 2010 and 2011, a significant increase in the number of people served occurred. The increase peaked in SFY 2012.

Table 48. Number of Individuals receiving Brain Injury Services by SFY					
State Fiscal Year	2009	2010	2011	2012	2013
Number served	9,917	11,800	20,700	23,268	19,744

Source: Department for Aging and Rehabilitative Services.

In 2013, the Commonwealth Neurotrauma Initiative Trust Fund Advisory Board awarded a one-year contract of \$150,000 to Brain Injury Services, Inc. in northern Virginia to implement a community-based model of wrap-around supports and intervention services for individuals with brain injury and challenging behaviors. The services will be delivered in two localities: one rural (Harrisonburg and surrounding areas) and one urban (Northern Virginia region). This grant, which will serve up to 20 individuals in each program, requires an evaluation of each program’s effectiveness. This grant program will begin services during 2014.

Table 49 shows the number of individuals served by the DARS **Woodrow Wilson Rehabilitation Center’s (WWRC) Brain Injury Services** for selected years between SFY 2005 and 2013.

Table 49. Number of Individuals receiving Brain Injury Services through WWRC by SFY						
State Fiscal Year	2005	2007	2010	2011	2012	2013
Number served	123	132	132	199	165	159

Source: Department for Aging and Rehabilitative Services, Woodrow Wilson Rehabilitation Center.

3. Cost and Payment for Brain Injury Services

The **Brain Injury Services Coordination (BISC) Unit** manages the state and federal funding designated for brain injury services that is received annually by the Department for Aging and Rehabilitative Services (DARS). State appropriations for BISC Unit operations have been relatively stable for the past 15 years, which has been approximately \$181,000 annually for the past few years. State appropriations to fund contracts with BI service providers are listed by state fiscal year in **Table 50**.

State Fiscal Year	2010	2011	2012	2013	2014
BIS contracts	3,881,000	\$3,881,000	\$3,821,333	\$3,886,466	\$3,991,466

The Brain Injury Services Coordination (BISC) Unit at DARS additionally administers a “fund of last resort” for eligible individuals with an acquired brain injury: the **Brain Injury Direct Services (BIDS) Fund**. The BIDS Fund is available to applicants who have no other public or private source of funds available (Medicaid or Medicare, private insurance, or other DARS assistance) to pay for needed technology or services that will enhance independence and recovery. The BIDS Fund supports services typically provided on an outpatient basis in community settings such as:

- neuropsychological assessment or counseling;
- neurobehavioral assessment and intervention;
- medical, speech, physical, occupational, cognitive, and other rehabilitation therapies;
- assistive technology (AT) assessments and purchase of recommended AT equipment; and
- life skills training, among others.

Eligibility criteria are available on the DARS website at http://www.vadrs.org/formscabinet/documents/public/bids%20fund%20eligibility%20criteria_cbs204.pdf. Before completing the required BIDS Funds application, individuals are urged to first contact the BISC Unit to see if funds are available. Call the Unit toll-free at (800) 552-5019 or check online at <http://www.vadars.org/cbs/biscis.htm>.

BIDS funds come solely from state General Fund appropriations, which have been very limited and currently are \$151,324 a year. Of that amount, \$65,000 annually is designated for used by the DARS contract BI service providers (\$5,000 each in SFY 2013) to use only for direct (“case”) services to individuals. Each provider must monitor and report use of the BIDS funds at the end of each state fiscal year. In addition, BIDS funds may be used periodically as the “state cash match” for the DARS federal Traumatic Brain Injury Grant.

The BIDS Fund data shown in **Table 51** provide the total number served, wait list numbers, and total expenditures for select SFYs between 2009 and 2013. Data are based on reports by brain injury service providers under contract with DARS. “Recipients” refers to all those who received direct BI services during the SFY. As the data indicate, the number of recipients increased in SFY 2013. Prior to that SFY, the number of individuals receiving BI services through the BIDS Fund was reported in aggregate as part of the total number served by the BI provider. Beginning in SFY 2013, DARS asked its contract BI providers to account separately for service recipients supported through the BIDS Fund.

Table 51. BIDS Fund Expenditures by SFY			
SFY	Number of Recipients	Number On Waiting List	Total Expenditures
2009	28	n/a	\$96,325
2010	15	8	\$140,343
2011	45	n/a	\$95,343
2012	30	n/a	\$55,451
2013	224	40	\$131,325

Source: Department for Aging and Rehabilitative Services.

The wait list number is the count of those eligible and waiting for funds to become available at the end of each SFY (June 30). Due to limited funding and staff, wait list data are sometimes not available or reported. BIDS Fund expenditures varied considerably from year-to-year during the past five SFYs. Although some variation is attributed to differing levels of BI service needs for individuals each year, most of the variability is attributed to state budgetary limits.

As noted earlier, the **Woodrow Wilson Rehabilitation Center (WWRC)** provides services to individuals with brain injury on both a residential and outpatient basis. WWRC reports that annual expenditures for these specific services are not delineated in the overall facility operational budget. An individual with brain injury, for example, receives varied rehabilitative services from several programs within the Center. The entire WWRC had a total annual budget of almost \$26 million dollars each year in SFYs 2013 and 2014, of which only 19 percent was from state General Funds. The remaining 81 percent was from federal funds.

4. Monitoring and Evaluation of Brain Injury Services

The manager of the Department for Aging and Rehabilitative Services’ (DARS) **Brain Injury Services Coordination (BISC) Unit** is responsible for oversight of Brain Injury (BI) services and other related DARS programs, including the 13 contracted BI direct services programs statewide. Expenditures, activities, and outcomes are routinely monitored; the BISC manager reports issues of significance or concern to the Community Based Services (CBS) Division director and DARS commissioner on a weekly basis. Written reports are submitted annually to

the DARS commissioner via the **Virginia Brain Injury Council**, for which the BISC Unit provides staff, 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 distribute 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. This Council considers formal suggestions and concerns raised by these organizations and other community partners or those raised internally by DARS staff. As indicated, the Council brings this information and any recommendations to the attention of the CBS Division director and DARS commissioner so that policy and procedure changes or other appropriate actions, if feasible, can be taken. The BI Council annually develops a "Priorities Letter" for legislative funding and actions that is sent to the DARS commissioner. Since 2010, the top priority has been creation of neuro-behavioral services. Other priorities identified in 2013 are access to specialized case management, and an effective, affordable system of transportation to access services. For more information on the Brain Injury Council, go online to <http://www.vadrs.org/vbic.asp>.

Organizations contracted by DARS to provide brain injury services are required to comply with state fiscal policies and procedures, including submission of 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 either from internal or external efforts. In addition, in recent years the BISC Unit has required all BI contractors to be accredited by the national **Commission on Accreditation of Rehabilitation Facilities (CARF)**.

Since SFY 2008, the BISC Unit has been conducting programmatic and fiscal evaluations on a minimum of two providers each year, as Unit staff level allowed. Evaluations focus on contractual compliance and service quality. In SFY 2011, BISC Unit staff found several areas of non-compliance by one organization, which ultimately led to the provider ending the contract with DARS. DARS was successful in soliciting new contractors who were able to provide BI services without disruption to consumers. During SFY 2013, staff from the BISC Unit and the DARS Office of Policy and Planning conducted site visits for program evaluation, which will be continued as staffing allows. The BISC Unit now requires the board of directors of each contract provider to complete an annual *Control Self-Assessment Document*. Each board and executive director must use this tool to assess its agency's internal controls for fiscal and personnel management, among others. DARS additionally initiated mandatory information to and training of all boards on a quarterly basis. DARS now holds an annual Commissioner's Board/Council retreat for not only the governing and advisory boards of the BISC programs but also for all programs under the agency's administration.

Since 2007, the **BISC Unit** has required all providers to submit expenditure and outcome data quarterly through an online **SCORECARD system**. The SCORECARD enables DARS to routinely monitor contract compliance, efficiency, and effectiveness in a more structured manner. The SCORECARD system requires programs to submit data and information to the BISC Unit manager on progress towards performance goals and client outcomes, and it requires documented reasons for any performance measures that are below expectations. In 2013 DARS began extensive revision of the SCORECARD system to include client indicators for social, emotional, and behavioral health, and new financial reporting. This will be operational in SFY 2015.

The **Brain Injury Direct Services (BIDS) Fund** is monitored by the BISC Unit manager, who annually submits reports to the DARS commissioner on the number of individuals served as well as the types and costs of services funded.

Internal processes at DARS' **Woodrow Wilson Rehabilitation Center (WWRC)** govern program capacity and resource allocation for the Brain Injury Services (BIS) and all other programs. Guidance on services provided 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 the WWRC's director and the director of the Medical Division. Additionally, the WWRC Medical Division's Compliance Program audits individual case records to review admissions procedures, service provider documentation, medical coding, and billing practices. The Compliance Program regularly educates staff on compliance issues and provides quarterly reports to the WWRC executive team.

WWRC has maintained accreditation for its programs from various national organizations, which set professional standards for clinical services, vocational services, and facility/equipment of both residential and outpatient programs. Included here are accreditations cited in the 2013 WWRC annual report. Its Medical Rehabilitative Division has been certified as a Comprehensive Outpatient Rehabilitation Facility (CORF) provider. In March of 2012, this division received recertification for four years with no deficiencies. The WWRC Durable Medical Equipment (DME) Department has full accreditation from the Accreditation Commission for Health Care (ACHC), which was recertified in November of 2012 for three years. The WWRC Vocational Training Department is accredited by the Commission of the Council on Occupational Education (CCOE), which recertified the program in 2013 for five years.

D. Spinal Cord Injury Services

This section focuses solely on the outpatient and residential services provided to individuals with spinal cord injuries at the **Woodrow Wilson Rehabilitation Center (WWRC)**, located in Fishersville, Virginia. The goal of these services is to provide individualized, comprehensive evaluations and rehabilitation services that promote functional recovery, self-sufficiency, and vocational preparation.

1. Eligibility for Spinal Cord Injury Services

Eligibility for the **WWRC Spinal Cord Injury Services** has similar requirements as the brain injury services program: individuals must have potential for rehabilitation or employment and must be medically and psychiatrically stable. Priority is given to individuals who are receiving vocational services through DARS. (For complete information, go to <http://www.wwrc.virginia.gov/spinalcordinjury.htm>.) To be admitted into the WWRC for residential SCI services, an individual with a spinal cord injury must be 18 years of age or older.

Individuals served by the outpatient **Spinal Cord Injury (SCI) Clinic**, held once a month, typically includes those who:

- have a recent injury;
- have had a SCI for several years and have experienced gains in functioning since they received rehabilitation; and
- are able to do less for themselves than when they first returned home from rehabilitation.

2. Access to and Delivery of Spinal Cord Injury Services

Residential SCI services at WWRC are provided by an interdisciplinary team of experienced clinicians who provide a wide variety of evaluations, medical rehabilitation, vocational assessment and training programs to maximize each individual's neurological and functional recovery. The SCI clinical team includes a physiatrist; nurses; personal care assistants; physical, occupational, and speech therapists; psychologists; vocational evaluators; vocational educators; and case managers. Residential services are broad in scope and include, but are not limited to:

- assistive technology (AT) evaluation and training,
- attendant care training,
- counseling,
- driver's evaluation and training,
- health promotion,
- independent living skills,
- family education,
- wheelchair evaluation and adaptation, and
- community re-entry.

Upon completion of their medical rehabilitation programs, residential clients are referred to either WWRC's outpatient Spinal Cord Injury Clinic or to community resources for follow-up evaluations and services. The outpatient clinic is held monthly.

Individuals may contact either the WWRC Admissions Office or the Spinal Cord Injury program coordinator by email at SCIProgramInfo@wwrc.virginia.gov or by phone at (800) 345-9922, Ext. 7118 or (TTY) (800) 811-7893. The clinic is staffed by a multi-disciplinary team of experienced rehabilitation professionals (physiatrist, nurse, occupational therapist, and physical therapist). The SCI Rehabilitation Team provides evaluation and assessment of each client’s needs and potential in the following areas:

- bowel and bladder care,
- skin integrity and pressure sores,
- posture,
- range of motion,
- strength,
- functional mobility skills (such as transfers),
- wheelchair mobility,
- assistive technology (in some cases), and
- activities of daily living (in some cases).

3. Availability of Spinal Cord Injury Services

Listed in **Table 52** is the number of individuals with SCI served by the DARS **Woodrow Wilson Rehabilitation Center’s (WWRC) Spinal Cord Injury Services** for selected years between SFY 2010 and SFY 2013. Prior to SFY 2010, the SCI services counts did not include individuals with spinal cord injuries who may have been served in other programs at WWRC. Improvements to WWRC’s data system that year allowed it to track individuals with spinal cord injuries receiving services from its programs other than SCI services, which in SFY 2010 totaled 27 individuals in addition to the 200 reported below. Since then, according to WWRC staff, counts have been impacted by changes to the diagnostic categories and definitions required by its federal funding agency as well as budget reductions at the state and federal levels.

Table 52. Individuals Receiving Spinal Cord Injury Services through WWRC by SFY				
State Fiscal Year	2010	2011	2012	2013
Number Served	200	153	111	111

Source: Department for Aging and Rehabilitative Services, WWRC

4. Cost and Payment for Spinal Cord Injury Services

Expenditures for SCI services alone are not available. The WWRC *Agency Strategic Plan for 2012–2014* notes that 81 percent of its annual allocations during that period were from Non-General Funds (Non-GF), i.e., federal funds. The annual total WWRC budget for SFYs 2013 and 2014 has been the same for each year: \$4,856,457 in state General Funds (GF) and \$21,098,757

in Non-GF. Of the total allocation in each of those SFYs, Medical Rehabilitative Services, which includes clinical/rehabilitative services and assistive technologies, received \$1,958,567 in state GF and \$6,328,969 in Non-GF.

5. Monitoring and Evaluation of Spinal Cord Injury Services

Oversight activities for SCI services are the same as those described in the **Monitoring and Evaluation of Brain Injury Services** section above.

E. Community Rehabilitation Case Management Services

Code of Virginia § 51.5-123, as amended by the 2014 legislature, directs the **Department for Aging and Rehabilitative Services (DARS)** to

develop and implement a community rehabilitation case management system ... [for] ... coordination of medical, psychosocial, vocational, rehabilitative, long-term care, and family and community support services for persons with significant physical or sensory disabilities.

The overarching goal of the **Community Rehabilitation Case Management (CRCM)** program, located within DARS's **Community-Based Services Division**, is to link individuals to the services that will improve quality of life as well as prevent, reduce, or eliminate economic and personal dependency.

1. Eligibility for and Types of CRCM Services

Community Rehabilitation Case Management (CRCM) staff links individuals who have severe, long-term physical or sensory disabilities with appropriate community rehabilitative services and supports. Program staff additionally provides outreach and support services to residents of nursing facilities and provides Support Coordination Services to recipients of Virginia's Individual and Family Developmental Disabilities Support Waiver (DD Waiver) under Medicaid. This section focuses only on non-Medicaid Waiver case management. (See the **Medicaid** chapter of this *Assessment* for information on case management under the Medicaid Waivers.)

CRCM rehabilitation specialists provide case management to Virginians who meet both disability and financial need criteria. As defined in Code of Virginia § 51.5-124, individuals eligible for this service include those who:

- have a developmental disability,
- are "disabled indefinitely" and require services for an extended or lifelong period, or
- have a disability that results in "substantive functional limitations" in three or more life activities, including economic self-sufficiency.

By statute, CRCM services cannot be provided to anyone who is eligible for Medicaid targeted case management or transition coordination or any other publicly funded case management program.

Due to limited resources, four Priority Levels for CRCM services exist. In all levels, preference is given to public safety officers and military veterans who were disabled in the line of duty. Descriptions of CRCM services, eligibility, and priority levels are found online at <http://www.vadrs.org/cbs/ltrcm.htm> or by contacting a local DARS office.

2. Access to and Delivery of CRCM Services

CRCM rehabilitation specialists work in the Richmond central office and in regional offices statewide: Abingdon, Christiansburg, Fishersville, Fredericksburg, Hampton, Lynchburg, Portsmouth, and Richmond. Locations and contact information are available online at <http://www.vadrs.org/formscabinet/documents/public/bids%20fund%20eligibility%20criteria%20cbs204.pdf> or by calling the CRCM manager at 1-800-552-5019. CRCM staff collaboratively works with each individual to identify needed services, assists with linkages to services, and coordinates and monitors service delivery to ensure that clients' evolving needs are met.

3. Availability of CRCM Services

The number of individuals who can receive CRCM services varies from year to year due to limited funding and staffing levels as well as variability in the level of individuals' service needs. When a staff vacancy occurs, services are reduced until the position is refilled. The CRCM division does not have a funded case manager position designated for Northern Virginia. **Table 53** identifies the number of individuals receiving CRCM services between SFYs 2008 and 2013.

State Fiscal Year	2008	2009	2010	2011	2012	2013
Number served	497	465	708	580	588	655

Source: Department for Aging and Rehabilitative Services

4. Cost and Payment for CRCM Services

CRCM services are, and have been, reliant on state General Funds. The DARS Community Based Services Division, of which CRCM is a part, however, regularly seeks grant funds, when available and appropriate, not only for CRCM but also other division programs to augment state funding. According to CRCM division staff, the annual budget appropriation for CRCM services has been flat since SFY 2005 with appropriations of \$507,643 each year through 2013. Additional state funds, however, may be transferred to CRCM services from other divisions or programs within DARS (e.g., BIDS Fund, BISC Unit, etc.) to address needs for specific populations or address waiting lists.

5. Monitoring and Evaluation of CRCM Services

Responsibility for oversight of CRCM Services rests with its program manager and the director of the Community Based Services (CBS) Division within the Department for Aging and Rehabilitative Services (DARS). Monitoring processes have remained constant over time. The CRCM program manager conducts record reviews and reviews results of customer satisfaction surveys conducted by regional offices. Based on findings, the manager identifies issues or problems to be addressed and updates policies and procedures as indicated. Concerns are forwarded to the appropriate rehabilitation specialist or assistant DARS commissioner as needed.

F. Comprehensive Services Act for At-risk Youth and Families

Enacted in 1993, the Comprehensive Services Act (CSA) is a state law (Code of Virginia, 2.2-5200 et seq.) that established a single, state pool of funds comprised of monies from eight funding streams across four state agencies. This pool funds local services to youth and the state **Office of Comprehensive Services (OCS) for At-Risk Youth and Families** to administer and monitor both the services provided and their compliance with designated fund uses. The CSA charge 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.

CSA goals include the following:

- early identification of and intervention for at-risk youth,
- family preservation,
- more flexible use of available funds,
- reduced disparities in service access across localities, and
- the provision of services appropriate to individual needs “in the least restrictive environment while protecting the welfare of children and maintaining the safety of the public.”

Under CSA, local inter-agency collaboration and public/private partnerships are expected to promote community responsibility for developing and delivering needed services to youth in the area.

1. Eligibility for CSA Services

Because funding streams across four state agencies that have multiple federal mandates to meet, multiple eligibility criteria for services exist under the Act. Broad eligibility criteria are listed online at http://www.csa.virginia.gov/html/for_parents/for_parents.cfm. To explore eligibility, agencies and parents should contact either a local CSA coordinator through the

online CSA coordinator roster at http://www.csa.virginia.gov/rosters_reporting/coord3a.cfm, or contact the state Office of Comprehensive Services at (804) 662-9815 or by email at csa.office@csa.virginia.gov.

Detailed descriptions of the CSA target populations are found in § 2.2-5212 of the Code of Virginia. At a minimum, to be eligible, the youth must meet one of these criteria:

- be in foster care or be eligible for foster care;
- require private placement for special education;
- be eligible for services through a Child-in-Need of Services Parental Agreement through agencies other than local departments of social services; or
- have significant emotional or behavior problems that are persistent over time and may require services either not available from an agency or require services from multiple agencies, or may be at risk of residential placement.

For the purposes of defining eligibility of youth for state pool funds, the age eligibility criteria for CSA mirrors the age criteria for foster care services and special education services. (See the **K–12 Screening and Eligibility for Part B Special Education** section in the **Education** chapter of this *Assessment*.)

Localities may choose to serve non-mandated youth with emotional or behavioral problems who meet CSA eligibility criteria, but there is no legal requirement that local governments provide the matching funds to do so. According to statewide data from the Office of Comprehensive Services, since state fiscal year (SFY) 2000, the program has predominately served youth in the mandated category. Statewide data on annual CSA utilization and expenditures is online at http://www.csa.virginia.gov/publicstats/csa_pool.cfm.

2. Access to and Use of CSA Services

Referrals to the CSA program can be made by family members, schools, or staff at human service, health, and public safety agencies. In accordance with local policies, the referring source should contact the local **Family Assessment and Planning Team (FAPT)** or the local CSA coordinator for an assessment. The CSA website provides a list of local FAPTs.

According to data from the state Office of Comprehensive Services, historically, referrals to CSA most frequently come from staff in local social services departments and school divisions because youth in foster care or with special education needs are mandated populations for CSA. These two referral sources consistently accounted for more than 80 percent of all referrals each year. The other main referral sources have been the juvenile justice system and the local Community Services Boards (CSBs). Over time, less than 4 percent of youth referrals came from interagency teams, families, health providers, or other sources. During SFY 2013, referrals came from the following sources:

- 59.4 percent referred by local social services departments;

- 24.2 percent referred by schools;
- 7.4 percent referred by juvenile justice; and
- 6.6 percent referred by Community Service Boards (CSBs).

Whether in a mandated or non-mandated category, all youth must be assessed by the local **FAPT**. Family members may contact the local CSA coordinator for information. User-friendly information for parents about access and delivery of CSA services, including the responsibilities of FAPTs, is provided online at http://www.csa.virginia.gov/html/for_parents/for_parents.cfm. Access procedures vary by locality. Some localities allow parents to contact the FAPT team directly, while others require referral from a local agency. Additionally, some FAPTs require that one of its team's participating agencies serve as the point of contact for a family.

The FAPT is responsible for developing the appropriate service plans for each youth who is referred. With active participation by the youth and family members, the FAPT then must assess the strengths and needs of those youth and their families accepted for services. Since SFY 2009, all youth eligible to receive CSA services must be evaluated using the **Child and Adolescent Needs and Strengths (CANS)**, a standardized assessment instrument. After completing the assessment, the FAPT develops an **Individual Family Services Plan (IFSP)** that identifies the services required to meet their unique needs, and makes recommendations for funding to appropriate local services. If the family agrees with the plan, the FAPT assigns a case manager to work with the youth and family in implementing the service plan. The FAPT and the case manager are responsible for identifying service providers to address needs.

The FAPT may use CSA pool funds to purchase services if all of the following criteria are met:

- a family's needs cannot be met by the participating agencies;
- there are no other community resources available; and
- the youth meets CSA eligibility requirements.

If a family disagrees with the service plan, they may ask for a review in accordance with local policies by the local **Comprehensive Policy and Management Team (CPMT)**, which has management and administrative responsibilities for CSA activities. However, any necessary emergency services can proceed while this review occurs.

The **Office of Comprehensive Services (OCS) for At-Risk Youth and Families** (<http://www.csa.virginia.gov>), which administers the CSA program, reports that there has been a gradual decline in the number of youth served during each SFY since 2000. According to CSA data, the number served has declined by 20.3 percent, dropping from a peak of 18,458 youth served in SFY 2007; 16,567 youth served in SFY 2011; and 14,729 youth served in SFY 2013.

Since 2008, the CSA program has emphasized services to youth in their own communities in order to maintain natural supports and to reduce costs. That year, the legislature authorized

financial match incentives for that purpose. The State Executive Council for CSA established a hierarchy of service categories with an accompanying incentive rate match system. In addition, the Children’s Services Systems Transformation initiative was implemented statewide. (More information on this initiative is included in the **Available CSA Services** section of this chapter below.) The impact of these initiatives can be seen in **Table 54**, which depicts utilization data for admissions to various residential settings. The last row indicates the unduplicated number of youth served in residential settings. It is lower than the admission counts for each SFY because one youth may have had more than one residential admission during the year.

Table 54. CSA Admissions to Residential Settings by SFY					
Type of Residence	2010	2011	2012	2013	% Change
Temporary care facility	93	190	187	145	+ 55.9 %
Group Home	1,248	1,088	908	802	- 35.7%
Residential treatment	1,331	1,269	1,233	1,176	- 11.6%
Total admissions	2,672	2,547	2,328	2,123	- 20.5%
Total unduplicated youth served	2,360	2,236	2,054	1,888	- 20.0%

As defined by the CSA State Executive Council, a “temporary care facility” is defined as

placement of youth outside their family homes in licensed facilities or emergency shelters that serve groups of youth and are specifically approved to provide a range of services as needed, on an individual basis not to exceed 90 days.

Services provided while the youth is living in this facility include assessments, crisis stabilization, respite, or other outpatient services to the youth as well as services to the youth’s planned permanent caregiver, which are provided either in the facility or in the community. Excluded from the definition of temporary care facility are secure detention facilities.

The increased provision of CSA-funded services in communities additionally is evident in data on the proportion of youth served in various community settings, which are provided in **Table 55**. “Family-like settings” refer to family foster homes or therapeutic foster homes; and “licensed residential settings” refers to those such as intensive treatment services, group homes, or temporary shelter care. Data are the proportion of all youth who were served under CSA in a particular setting category. Percentages for each year may not total 100 percent due to rounding.

Table 55. Proportion of Youth Served under CSA by Setting Type and SFY			
Type of Setting	2008	2010	2013
In the community or in schools	34%	42%	43%
Family-like settings	47%	39%	40%
Licensed residential settings	17%	19%	16%
Psychiatric hospitals	< 1%	< 1%	< 1%

Source: Office of Comprehensive Services, January, 2014.

Between SFYs 2008 and 2013, the proportion of youth served under CSA who received services in the community or in school increased by 9 percent, from 34 to 43 percent, respectively. During the same time period, those receiving CSA-funded services in family or therapeutic foster homes declined by 7 percent, from 47 percent to 40 percent.

3. Available CSA Services

The Family Assessment and Planning Teams (FAPT) are responsible for identifying, planning, and coordinating services for CSA-eligible youth that 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. Since 2008, financial incentives and program policies have been in place for community-based services rather than residential placements under CSA (Code of Virginia 2.2-5211.1).

According to CSA utilization reports, eligible youth, a large proportion of whom have mental health challenges, generally receive more than one of the services available during any year. For the last several years, the following are the most frequently used services under CSA statewide:

- mentoring,
- intensive in-home services,
- intensive care coordination,
- out-patient therapy,
- parent education and skills training,
- treatment foster care, and
- private day special education.

For several years, the **Office of Comprehensive Services (OCS)** has worked closely with the Department of Social Services (DSS) to implement the **Children’s Services System Transformation** initiative. Its systemic goal has been to improve local services to youth and their families, to increase use of community services, and to ensure adoption of person-centered practices. As part of the initiative, clearer values and principles for CSA services were developed and disseminated, and implementation of a “Family Engagement Model” for youth in or at-risk of foster care was completed. This model promotes involvement of a child’s extended family and natural supports into the CSA decision-making processes. Ongoing training to members of local agencies, providers, and CSA teams has been provided to develop consistency across local programs. The *2013 Agency Executive Progress Report* from OCS notes that the initiative, now completed, achieved its goals.

In SFY 2013, the Department of Behavioral Health and Developmental Services was able to obtain federal grant funds to establish the **Virginia Wraparound Center of Excellence** within the **Office of Comprehensive Services (OCS)**. This four-year grant project, funded by the US Substance Abuse and Mental Health Services Administration (SAMHSA), is to implement the national **High Fidelity Wraparound (HFW) model of care** statewide. The Office of Comprehensive Services will be the project home and administrator. The project targets youth who have complex behavioral health needs and who are involved in one or more of these service systems:

- child welfare,
- juvenile justice,
- mental health, or
- special education.

The project goal is to integrate services to either (1) enable youth to return to their families and communities from various congregate and institutional settings or (2) enable youth at risk of out-of-home placements to stay with their families. This model of care requires extensive trainings to assist with skill development for members of each local FAPT and CPMT, local Community Services Boards (CSBs), and private providers.

In April of 2013, the CSA State Executive Council adopted a policy approving HFW as a model of care as well as the accepted practice for all **Intensive Care Coordination services** under CSA. Authorized in the 2009 Appropriations Act, Intensive Care Coordination (ICC) is a CSA service, wherein IC coordinators work to provide more comprehensive services around a family (“wrap”) that will support a child to stay or return home. More information is available at <http://www.csa.virginia.gov/>. Through this project, statewide monitoring of intensive care coordination will be improved. To maintain quality, annual training of the IC coordinators will be required.

4. Cost and Payment for CSA Services

CSA is primarily funded through the state General Fund, as appropriated by the General Assembly, and through local match. State and local governments share funding for services under the CSA based on a formula, and some services are reimbursed under the Medicaid State Plan for enrolled youth. 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-scale fee. **Table 56** provides the annual budget for CSA for state fiscal years (SFYs) 2011 through 2014, including the proportion of funding, by source.

State Fiscal Year	State General Fund	Non-General Funds	Total Budget
2011	\$271,234,333 (82.5%)	\$57,608,877 (17.5%)	\$328,843,210
2012	\$270,060,815 (83.7%)	\$52,607,746 (16.3%)	\$322,668,561
2013	\$225,423,724 (81.1%)	\$52,607,746 (18.9%)	\$278,031,470
2014	\$217,197,736 (80.5%)	\$52,607,746 (19.5%)	\$269,805,482

Non-General Funds are comprised of federal monies from the national Social Services Block Grant and the Catalogue of Federal Domestic Assistance (CFDA #93667).

Between SFYs 2011 and 2014, the CSA annual budget decreased by 18 percent (\$59,037,728) with most of the decrease from the state General Fund. As noted in the 2013 CSA utilization report, the decrease in state appropriations in SFYs 2013 and 2014 was based on both the declining number of youth served and the declining use of residential services. The number of youth in foster care has been declining over time. For several years, the state Department of Social Services has had initiatives to promote family integrity and, as needed, more permanent placements for foster care youth. In addition, according to OCS staff, some of the decline in number served relates to technical guidance and assistance to local teams that clarified appropriate use of funds for foster care youth in special education.

The Office of Comprehensive Services (OCS) produces and posts online numerous studies on service utilization and expenditures each year. The OCS *2013 Strategic Plan Executive Progress Report* notes that the number of youth served in residential facilities has steadily declined since SFY 2009, falling by 33 percent between 2009 and 2012. During that same period, total net expenditures for residential care also declined.

Table 57 below describes CSA service utilization and costs for SFYs 2010 and 2012 by population category (mandated vs. non-mandated). For financial reporting purposes, the category of “state funds” includes federal Social Services Block Grant monies for services under the CSA, which are provided through the Virginia Department of Social Services (DSS). Local

governments are the source of “other funds.” The “average cost” is a calculation of the total costs divided by number of youth served by category.

Table 57. CSA Expenditures by Funding Source and Populations Served for SFYs 2010 and 2013					
Population	Number Served	State Funds	Other Funds	Total Cost	Average Cost
2010 Mandated	16,193	\$226,403,047	\$113,558,880	\$339,961,927	\$20,994
2010 Non-Mandated	1,375	\$4,875,593	\$2,064,484	\$6,940,077	\$5,047
2010 Totals	17,568	\$231,278,640	\$115,623,364	\$346,902,004	\$19,746
2013 Mandated	13,495	\$199,341,755	\$109,513,144	\$308,854,899	\$22,887
2013 Non-Mandated	1,234	\$3,915,528	\$1,443,641	\$5,359,169	\$4,343
2013 Totals	14,729	\$203,257,283	\$110,956,785	\$314,214,068	\$21,833

Source: Office of Comprehensive Services.

As the data indicate, both expenditures from state and other sources declined as did the total number of youth served under CSA. Between SFYs 2010 and 2013, the average cost per youth in a mandated-CSA category actually increased by 9 percent (\$1,893). By comparison, the average cost per non-mandated youth decreased by 14 percent (\$704).

5. Monitoring and Evaluation of CSA Services

The organizational structure and oversight provisions of the CSA are complex and cannot be fully detailed here, but basic features are described. State-level oversight consists of a two-tiered, multi-agency system. At the highest level, the **State Executive Council (SEC)** for the CSA is chaired by the Secretary of Health and Human Resources (or designee). Its other members, who are identified in the Code of Virginia, 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; and two parents. The SEC is responsible for:

- overseeing the interagency cooperation and collaboration necessary to implement CSA at both the state and local levels,
- appointing state and local advisory team (SLAT) members,
- establishing appropriate programmatic and fiscal policies,
- providing oversight of the use of CSA pool funds, and
- advising the Governor and Cabinet Secretaries on proposed policy and operational changes.

During the next biennium (SFYs 2015 and 2016), the SEC will be concentrating on three over-arching goals:

1. support implementation of a singular, unified system of care that enables equal access to needed services for at-risk youth;
2. support informed decision-making through data analysis to improve service outcomes for youth and their families; and
3. improve the operational effectiveness of CSA administration.

The **State and Local Advisory Team (SLAT)** comprises the second tier of the state CSA system, advising the State Executive Council on policy and related issues. SLAT membership includes staff members from relevant state agencies, parent and provider representatives, one judge, one local CSA coordinator, and five regional representatives who serve on a local Community Policy and Management Team (CPMT).

The **Office of Comprehensive Services (OCS) for At-Risk Youth and Families** is the administrative entity responsible for implementation of services as the CSA's administrative body. OCS works in partnership with other state agencies, localities, family organizations, and other stakeholders to improve CSA performance and ensure compliance with SEC and legislative policies. The OCS is responsible for policy development, fiscal management, data collection and management (including a database of authorized providers); and for technical assistance to and oversight of local CSA activities. For quality assurance, OCS coordinates resources, training, best practices dissemination, and management reports to support community CSA systems. When requested by localities, OCS provides utilization management for some residential programs.

The Office of Comprehensive Services (OCS) conducts both routine and special compliance/formal audits of local operations, which include on-site visits. The OCS audits are to ensure that CSA 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. Based on review findings, OCS identifies local training and technical assistance needs. If program specific concerns are found, staff from appropriate agencies may be called in to assist in the review process. Following any 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.

In 2007, the Joint Legislative Audit and Review Commission (JLARC) published its research report, *The Evaluation of Children's Residential Services Delivered through the Comprehensive Services Act* (<http://jlarc.virginia.gov/reports/RPT346.PDF>). Since then, to strengthen CPMT and FAPT performance, the OCS has developed and provided training on service models for needs assessments, policy guidelines, assessment tools and skills training, and systems coordination,

among other topics. OCS staff is available to provide CMPTs and FAPTs with ongoing training and consultation. Over time, the OCS has modified CSA data collection to capture provider-specific information, results from the Child and Adolescent Needs and Strengths (CANS) standardized assessment instrument, and generally improve data analytics for service evaluation and improvement planning.

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 Program Management Team (FAPT).

While municipalities are required by Virginia law to establish their own two-tiered systems involving a CPMT and a FAPT, they are otherwise given considerable flexibility in designing and delivering CSA services that best fit their situations. To ensure CSA services are appropriate, cost effective, clinically effective, and in compliance with CSA policies, localities must have a system in place for review of extensive client data (including reasons for referral and planned services) as well as program data on service delivery, quality, and costs. Local reviews may also identify technical assistance and training needs and raise policy or procedural issues requiring attention.

The OCS develops an annual **Critical Services Gap Survey** regarding available community services, barriers to services, and service gaps at the local and regional levels. Local CPMTs meet, either by locality or regionally, to review and discuss data to determine needs as well as how to best address gaps. OCS staff sometimes facilitates meetings between the CPMTs and private providers regarding identified service gaps or to make connections that bring service providers to a locality or region. Although the top service gap for each CSA region may vary, since SFY 2004, annual surveys have found that: (1) **crisis intervention services for youth** are the most important critical service need statewide and (2) **intensive substance abuse services for youth** in the western, central, and northern regions of the State has been an ongoing, unfilled need.

Lack of local start-up funds to expand or develop needed critical services has been an ongoing barrier. In order to improve service development to address these gaps, the **CSA State Executive Council** adopted a **Carve Out Policy** at its April 2013 meeting. This policy allows a maximum of \$2 million dollars in state General Funds to be set aside from local CSA allocations in order to support one-time start up costs for new services. Availability of this fund is contingent upon future new state allocations.

G. Centers for Independent Living and Related Services

Independent living services are defined broadly as training, education, and support services that promote self-determination, empowerment, self-advocacy, self reliance, independence and productivity for individuals with disabilities, including those with significant disabilities. The

ultimate goal of these services is **integration and inclusion** of individuals with disabilities in their communities. Although a variety of public and private entities offer these services, independent living services are provided through two state-administered and funded programs (1) Centers for Independent Living (CILs) under the Department for Aging and Rehabilitative Services (DARS) and (2) the Rehabilitation Teaching/Independent Living (RT/IL) Program offered by the Department for the Blind and Vision Impaired (DBVI).

The Commonwealth's **Centers for Independent Living (CILs)** are nonprofit, community, non-residential agencies operated by and for Virginians with disabilities. Authorized under the federal Rehabilitation Act of 1973 (29 US Code § 701 et seq.) and the Code of Virginia § 51.5-162, CILs help individuals with disabilities to develop or improve various skills for independent functioning in the family or community, or to gain or continue their employment. CILs additionally inform, advise, and work with local or regional political leadership and planning entities to make communities more accessible and to ensure equal opportunities for citizens with disabilities. Regulations require that CIL staff and management be individuals with disabilities who have been trained in independent living philosophy (<http://www.DARS.virginia.gov/cbs/cils.htm>).

1. Eligibility for and Available CIL Services

As required by federal legislation, CILs prioritize services to individuals who have a significant physical or mental impairment and have substantial limitations in the ability to function independently in the family or community or to obtain, maintain, or advance in employment. CILs are required to provide four **core services**:

1. information and referral,
2. peer counseling,
3. advocacy, and
4. independent living skills training.

Helping individuals develop **advocacy skills** for personal and systems change is a fundamental part of the CILs' mission.

Most CILs provide additional services beyond these core responsibilities, such as linkages to housing resources or Medicaid and efforts to expand employment opportunities for people with significant disabilities. Many CILs hold recreational events that bring together local residents with and without disabilities. Although adults with disabilities or parents of youth with disabilities are primarily served, some CILs provide peer counseling, mentoring, and skills training programs for youth in local schools. In recent years, the CILs have partnered with the state Department of Medical Assistance Services (DMAS) to create a statewide network of staff who serve as **Medicaid mentors**. These mentors, extensively trained by DMAS staff, provide

technical assistance to individuals and families to apply for and access needed Medicaid benefits and services.

2. Access to and Use of CIL Services

Individuals needing assistance should contact the CIL office in or closest to their locality. Directories of statewide CILs are online at <http://www.vasilc.org/cillist.htm> and <http://www.vadrs.org/cbs/cils.htm>. At the end of SFY 2013, there were 15 Centers for Independent Living (CILs) and 4 satellite centers spread across 20 of the State's 23 planning districts. Not all areas of the State are covered. As of January of 2014, these locations had CILs: Abingdon, Arlington, Big Stone Gap, Charlottesville, Christiansburg (satellite), the Eastern Shore, Fredericksburg, Grundy, Hampton, Harrisonburg, Loudon (satellite), Lynchburg, Manassas, Middle Peninsula (satellite), Norfolk, Petersburg (satellite), Richmond, Roanoke, and Winchester. A 16th CIL covering Planning District 12 (Martinsville/Danville) will open in September of 2014. The **satellite locations** require annual appropriations to be designated for them to become freestanding CILs. A map of the CILs can be found at <http://www.vadrs.org/cbs/cilsmap.htm>.

CIL staff works directly and collaboratively with individuals with disabilities to identify needs and to develop a plan for independent living services that best meets the individual's needs and preferences. Each individual's **CIL plan** records mutual agreements on what services will be provided and how and when they will be delivered. CIL staff assists both individuals and family members in finding and accessing local support services or resources that will enhance independence and community integration.

CILs typically are unable to provide an unduplicated count of individuals served. An individual may contact a CIL multiple times during a year for different services. According to Department for Aging and Rehabilitative Services (DARS) data, CILs estimate serving at least 9,000 individuals each year since state fiscal year (SFY) 2010. Each CIL tracks the number of hours during which staff provides key services. In SFY 2012 (the latest data available), statewide, CILs services to community members with significant disabilities amounted to:

- 19,709 hours for information/referral to services,
- 18,433 hours of collaboration and networking,
- 15,659 hours in community education,
- 12,881 hours in outreach, and
- 6,027 hours of technical assistance for service access.

3. Cost and Payment for CIL Services

CILs are nonprofit organizations that receive funding from the local, state, and federal government as well as private sources. General operations are supported by federal funds (approximately \$1.5 million per year) through Title VII of the federal Rehabilitation Act. Federal

funding has been relatively flat in recent years, and even reduced due to sequestration. The majority of CIL funding comes from the state General Fund. In addition, each CIL solicits local and private funds, and either individually or through the Virginia Association of CILs seeks funding through competitive grants for particular projects. The total **expenditures by CILs** for SFYs 2010 through 2013 are listed in **Table 58**.

Table 58. CILs Expenditures for SFYs 2010 - 2013			
2010	2011	2012	2013
\$8,565,397	\$7,795,932	\$7,090,882	\$7,071,694

Source: Department for Aging and Rehabilitative Services.

As the data indicate, expenditures have varied based on funding. Between SFYs 2011 and 2013, expenditures declined by nearly 10 percent.

4. Monitoring and Evaluation of CIL 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 (DARS)** through the Independent Living Services office of its Community Based Services Division. DARS 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. CILs are actively engaged in statewide system change, such as increased access to Medicaid Home and Community Based Services (HCBS) Waivers and to transportation services, expanded housing options, and improved assistance to individuals who have transitioned from nursing facilities to community residences or who have needed services to avoid entering nursing facilities.

Since CIL core services are consumer-directed, feedback from the individuals with disabilities receiving services is a crucial part of service evaluation. 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 that is 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.

H. Independent Living Services for the Blind and Vision Impaired

Authorized under the 1973 Rehabilitation Act, as amended, and the Code of Virginia (Title 51.5, Chapter 12), the **Department for the Blind and Vision Impaired (DBVI)** is tasked to

provide vocational rehabilitation and other services to Virginians of all ages who are blind, deafblind or vision impaired, so they may become independent, contributing citizens. Although vocational rehabilitation is its primary goal, the DBVI programs have the equally important goal of fostering the personal independence of those with vision impairments. The DBVI's **Rehabilitation Teaching/Independent Living (RT/IL) Program** provides services to meet this goal (<http://www.vdbvi.org/RTILS.htm>).

1. Eligibility for and Available DBVI Independent Living Services

The **RT/IL Program** provides individualized needs assessments, adjustment counseling, information and referrals, and skills training. The DBVI RT/IL program specifically benefits 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. 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. Further information is available online at <http://www.vdbvi.org/services.htm>.

DBVI can provide intensive rehabilitation through its residential program, the **Rehabilitation Center for the Blind and Vision Impaired**, located in Richmond. Skills training programs cover self-advocacy and outreach, daily living, recreation, use of assistive technology, travel, vocational evaluation, home management, and forms of communication (including Braille). DBVI rehabilitation teachers, who are located across the State, generally also provide many services in an individual's home that promote independence. In addition to skills training and adjustment-to-blindness counseling to the individual, the rehabilitation center staff can educate and consult with family members, caregivers and others who wish to be of assistance to an individual with vision impairment. Staff also can arrange vision assessments and training with assistive technology.

The **Low Vision program**, which specifically serves persons who cannot see with conventional glasses, helps individuals maximize the vision that they have. Low Vision provides assistive technology, AT training and other specialized services, including visual examinations, optical aids, and follow-up services. DBVI **Orientation and Mobility training** teaches an individual to travel safely and independently as well as specific techniques to establish and maintain orientation to their surroundings. **Deafblind Services** provides additional specialized services for activities of daily living and especially for communication: skill assessments, adaptive equipment consultations, and technical assistance. RT/IL staff at DBVI additionally provides guidance, consultations and technical assistance to external public and private organizations, employers, and the general public regarding the unique needs of its target population.

2. Access to and Use of DBVI Independent Living Services

To request services, individuals or professionals should contact the regional Department for the Blind and Vision Impaired (DBVI) **Rehabilitation Teaching/Independent Living (RT/IL) Program** nearest them or the Department’s central office. DBVI staff provides intake and makes referrals for the RT/IL program, which has six regional offices across the State (Bristol, Fairfax, Norfolk, Richmond, Roanoke, and Staunton). RT/IL staff works directly with individuals needing assistance to explain services, establish visual eligibility, educate them on available resources, and refer them to appropriate DBVI programs and other community services. Once basic visual eligibility has been determined, the individual receives a functional assessment by a DBVI Rehabilitation Teacher, who then creates an individualized service plan most appropriate to the individual’s identified needs.

Essential to an individual’s success in school, employment, and community living is **orientation and mobility training**. Many individuals receive this training either at the regional DBVI office or in their homes or communities. For some individuals, independent living and orientation-to-blindness skills training occurs at the Virginia Rehabilitation Center for the Blind and Vision Impaired, a short-term residential program in Richmond.

The service capacity for programs under DBVI has varied over time, largely due to both funding constraints and the related difficulty in filling staff vacancies. **Table 59** depicts the number of individuals under age 55 served by each DBVI program for independent living skills for state fiscal years (SFYs) 2010 through 2013. Rehabilitative Teaching and Independent Living (RT/IL) services provided to those ages 55 years and older are counted under the Older Blind Grant Program (included in the **Services for the Elderly Population** section of this chapter). Prior to SFY 2010, the number served included all age groups and some non-active cases and counts for these programs were duplicative with the Older Blind Grant Program data.

DBVI Program/Service	2010	2011	2012	2013	Change (#/%)
Orientation and Mobility Training	562	487	641	411	- 151 - 26.9%
Independent Living (RT/IL)	460	472	439	423	- 37 - 8.0%
Deafblind Services	156	170	105	125	- 31 - 19.9%
Low Vision Services	953	1,129	1,082	1,013	+ 60 + 6.3%
TOTAL	2,131	2,258	2,267	1,972	--

The most significant decline in the number served between SFYs 2010 and 2013 were for the Orientation and Mobility Training service, which decreased by 26.9 percent (151 individuals), and the Deafblind Services, which decreased by 19.9 percent (31 individuals).By

contrast, the Rehabilitation Teaching/Independent Living (RT/IL) Program had only an 8-percent decline in the number served over those SFYs, and participants in Low Vision Services actually increased by 6.3 percent. During SFYs 2010 and 2011, DBVI had additional monies from the federal stimulus fund awards as a result of the American Recovery and Reinvestment Act of 2009 (ARRA). DBVI notes that some variation in the numbers served occurs between years due to varying levels of service needed in the communities or schools of the individuals referred to a program. As noted in the DBVI *2013 Executive Progress Report*, the pool of credentialed professionals who can provide orientation and mobility training still is limited statewide, and vacancies are sometimes difficult to fill.

3. Cost and Payment for DBVI Independent Living Services

DBVI receives federal funding for its vocational rehabilitation programs through the US Department of Education’s Rehabilitative Services Administration (RSA). It receives a separate federal grant for independent living services for older individuals who are blind under Title VII of The Rehabilitation Act. Federal funding has been flat in recent years, and in federal fiscal year (FFY) 2013, federal funds were cut by 5 percent due to sequestration. In SFY 2013, DBVI received \$6,301,368 in state General Funds. The appropriation was reduced to \$5,812,355 in SFY 2014, and, of the total DBVI budget for SFY 2014 (\$50.74 million), only 11.5 percent was from state General Funds.

DBVI additionally receives revenues each year from user fees, vending machine programs, and donations. Financial participation requirements, based on a formula intended to identify individuals with the greatest economic need, exist for the purchase of some equipment. While those meeting financial need guidelines can receive tangible goods and services at no cost, others may be required to pay some or all of the costs for certain goods and services. Financial need criteria are updated annually.

Table 60 lists DBVI expenditures by independent living program and related services for SFYs 2010 through 2013. Expenditures for Deafblind Services are indirect; rather than a direct use of funds for these specific clients. Independent living service expenditures for the deafblind population are incurred by the RT/IL and vocational rehabilitation programs that also serve those with visual impairments who are not deafblind. Distinct expenditure data for the Orientation and Mobility Training service are not available.

Table 60. DBVI Expenditures for Independent Living and Related Services by SFY				
DBVI Program/Service	2010	2011	2012	2013
Rehabilitation Teaching/Independent Living	N/A	\$41,212	\$99,574	\$70,760
Deafblind Services	\$140,320	\$19,000	\$26,000	\$26,400
Low Vision Services	\$506,175	\$224,882	\$263,367	\$238,432

Source: Department for the Blind and Vision Impaired.

While expenditures for the Rehabilitation Teaching/Independently Living Program increased, expenditures for the other two programs decreased substantially.

4. Monitoring and Evaluation of DBVI Independent Living Services

Oversight for the **Rehabilitation Teaching/Independent Living Program** within the Department for the Blind and Vision Impaired (DBVI) is the responsibility of its director, who is assisted by 6 regional managers. Each regional manager supervises and evaluates the performance of 22 rehabilitation teachers who deliver RT/IL services. The RT/IL Program director and regional managers also review case records and accompany the rehabilitation teachers in the field to monitor their effectiveness. Quality assurance procedures for the 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 provide direct services for the program's consumers. Periodic performance evaluations of these examiners are reviewed by the director for Low Vision Services and by regional leadership. If examiners are found to be non-compliant with DBVI policies and practices, their contracts may be cancelled.

The **DBVI central office** conducts annual case reviews for each of the regional offices and solicits feedback on services from DBVI's consumers 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. If RSA finds it to be non-compliant in any area, DBVI must submit a corrective plan indicating the actions to be taken and their projected completion dates.

The DBVI *2013 Strategic Plan Executive Progress Report*, as in the past, notes that attracting staff skilled in orientation and mobility training remains a challenge. DBVI anticipates greater demand for Low Vision and related services in the future as the number of Virginians who are elderly increases. Technology changes for accessibility increasingly "require a substantial investment of time and funding," which can impact funding available for direct services. DBVI established a **technology laboratory** through which staff can demonstrate cost-effective alternatives. DBVI also has worked to expand, and will continue to expand, partnerships with nonprofit and for-profit entities as well as public agencies to leverage its resources for direct services.

I. Intellectual Disability Services (Non-Medicaid Waiver)

Individuals with an intellectual disability (ID) may need supports or services that are not covered by the Medicaid ID Waiver, and others who are on the ID Waiver Wait List may lack private insurance coverage or the financial resources for needed services. The Virginia **Department of Behavioral Health and Developmental Services (DBHDS)** is responsible for

planning, monitoring, and overseeing all 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.

The **State Board for Behavioral Health and Developmental Services**, through State Board Policy 1038 (SYS) 06-1 (updated December 2013) affirms the responsibility of CSBs and DBHDS for assuring provision (either directly or through contracts) of a

safety net of appropriate public services and supports to the greatest extent practicable in safe and suitable settings.

This policy further states that this safety net responsibility covers those individuals who have a serious mental health or substance use disorder, intellectual disability, or co-occurring disorders and who

are in crisis or have severe or complex conditions; cannot otherwise access needed services and supports because of their level of disability, their inability to care for themselves, or their need for a highly structured or secure environment; and are uninsured, under-insured, or otherwise economically unable to access appropriate service providers or alternatives.

1. Eligibility for and Available (Non-Waiver) ID Services

To receive services, an individual must have a current diagnosis of intellectual disability as determined by a formal evaluation by a qualified professional. Additional eligibility requirements for specific CSB services exist based on the purpose of the service, parameters set by federal or state legislation, and the availability of local government funding. CSB staff determines ID service eligibility and coordinates service delivery. CSBs either contract with private providers for ID services or provide the services themselves. CSBs are required to

provide individualized, effective, flexible, and efficient treatment, habilitation, and prevention services in the most accessible and integrated setting possible.

For all CSBs, the Code of Virginia (§§ 37.2-500 and -601) mandates only emergency services as a required service, and gives a limited mandate for case management services, subject to legislative appropriations.

As noted in the DBHDS annual *Overview of Community Services in Virginia*, any combination of 10 core service categories may be available through a CSB:

- emergency services,
- limited services,

- consumer-run services,
- local inpatient services,
- outpatient counseling,
- case management,
- day support services,
- employment services,
- residential services, and/or
- prevention services.

In addition, CSBs either provide or contract for early intervention services to infants and toddlers.

Each service category is defined in the DBHDS **Core Services Taxonomy**, which was developed and is periodically updated by DBHDS in partnership with the Virginia Association of Community Service Boards (VACSB). **Limited services** typically are services that are provided short-term (less than 30 days or 4 to 8 sessions), infrequently, or are of low-intensity. Limited services include: assessments and evaluations; consumer monitoring services (for those on waiting lists or those who only receive service coordination, intermittent emergency contacts, or outreach); early intervention services; and motivational treatment services for individuals with mental health (MH) or substance abuse (SA) disorders. **Consumer-run services** are

self-help programs designed, governed and led by and for people in recovery.

These are typically individuals with MH or SA disorders, and services typically are provided through peer drop-in centers.

2. Access to and Use of (Non-Waiver) ID Services

Although legislatively accountable to local government, most CSBs operate as independent entities rather than as departments of city or county government. The service array at each CSB is unique, reflecting each CSB's own community priorities and available local resources. Each CSB determines its intake processes. To receive services from a CSB, an individual with an intellectual disability (ID) or his/her family member or caregiver must contact the local CSB serving the geographic area in which the individual lives. CSB staff then meets with the individual, and as appropriate, family members or caregivers, face-to-face. When eligibility for service is determined, the CSB "admits" or "enrolls" the individual, and opens a case record. 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 to address those needs is determined. Depending on the individual's specific needs, preferences and interests, an **Individual Support Plan (ISP)**, based on person-centered principles, is developed. This ISP guides the implementation of needed CSB services.

The biennial Performance Contract between each Community Service Board (CSB) and the Department of Behavioral and Developmental Services (DBHDS) identifies specific services that the CSB agrees to provide either directly or through contracts. Listed below are the unduplicated numbers of persons (children, adolescents, and adults) who received core ID [or developmental disability (DD)] services from CSBs for state fiscal years (SFYs) 2009 through 2013. Data are from the biennial DBHDS Comprehensive State Plans, the latest plan covering 2014 through 2020.

Table 61. Number receiving Non-Medicaid-Waiver ID or DD Services by SFY					
State Fiscal Year	2009	2010	2011	2012	2013
Number Served	27,172	19,374	20,387	20,562	20,248

DBHDS also reports the number of individuals who received specific ID/DD services. The number of individuals with ID who received **case management services** during the past four years was as follows:

- 17,530 individuals in SFY 2010
- 18,294 individuals in SFY 2011
- 18,376 individuals in SFY 2012
- 18,466 individuals in SFY 2013

The DBHDS Comprehensive State Plans also provide information on **unmet service needs** by disability area. The CSBs conduct a point-in-time survey (between January and April) to identify individuals who have sought any service and have been assessed by their CSB as needing a service that is not yet available. While the individual may be receiving one or more services through the CSB, he or she may still need another or additional services. CSB survey results are considered to be conservative estimates. Although more Medicaid Waiver slots have been funded annually in recent years, the number waiting for ID/DD services has grown over time:

- 5,216 individuals on waiting list in SFY 2005
- 5,992 individuals on waiting list in SFY 2007
- 6,458 individuals on waiting list in SFY 2009
- 6,415 individuals on waiting list in SFY 2011
- 7,806 individuals on waiting list in SFY 2013

In 2013, the most frequently identified ID/DD service needs for those on waiting lists were supportive services/day support and case management (especially for youth).

The Comprehensive State Plan additionally reports findings from the annual survey on the length of time individuals waited for a needed service. **Table 62** provides a comparison of survey data for SFYs 2009, 2011, and 2013. Until 2009, only the total number of individuals (youth and adults) was reported in the DBHDS Comprehensive State Plan. Beginning in 2011, separate totals were listed for youth and adults. The figures below are the totals calculated for both age groups.

Table 62. Length of Time on CSBs Waiting Lists for ID/DD Services by SFY			
Wait Time	2009	2011	2013 (changed metric to 0 to 3 months)
0 to 1 month	57	24	
1 to 3 months	766	546	720
4 to 12 months	1,048	832	977
13 to 24 months	1,112	956	1,149
25 to 36 months	709	897	867
37 to 48 months	608	722	830
49 to 60 months	500	480	756
61 to 72 months	387	431	649
73 or more months	1,209	1,473	1,979
Not reported	62	54	N/A
TOTAL	6,458	6,415	7,927

Source: Department of Behavioral Health and Developmental Services, *Comprehensive State Plans* for 2010–2016, for 2012–2018, and for 2014–2020.

The longest CSB wait times for individuals with ID/DD, according to the plan report, were for residential services (intensive and supervised) and employment services. For people with disabilities waiting for services provided under the Medicaid ID Waiver, the average wait time was at least 60 weeks for each of the following: personal emergency response systems (PERS), nursing services, assistive technology, and therapeutic consultations.

An additional measure of unmet service needs for individuals with ID is documented through the annual CSB survey and reported in the Comprehensive State Plan. The survey identifies the number of children and adults with an intellectual disability who are on a waiting list and who are not receiving *any* CSB services. Based on the point-in-time surveys, the number of these individuals on waiting lists was as follows:

- 938 individuals in SFY 2005
- 1,114 individuals in SFY 2007
- 1,342 individuals in SFY 2009
- 1,202 individuals in SFY 2011
- 945 individuals in SFY 2013

3. Cost and Payment for (Non-Waiver) ID Services

According to the DBHDS *2014–2020 Comprehensive Plan*, the agency’s total annual budget is funded by federal appropriations through various block grants and other programs as well as the Department’s federal share of Medicaid and Medicare reimbursements and state General Funds. These funds support *all* DBHDS-operated facilities and all contracted CSB services for individuals with a mental illness, intellectual disability, or substance abuse disorder. System funding additionally comes from fees, state Medicaid funds, and local matches. Total DBHDS revenue system-wide (CSBs and state facilities) for SFY 2012 was \$2.397 billion dollars, of which only 23 percent was from state General Funds. The sources of DBHDS funds for SFY 2012 were proportioned as follows:

- 30 percent from state Medicaid match
- 30 percent from federal Medicaid funds
- 23 percent from state General Funds
- 10 percent from local match
- 4 percent from other fees
- 3 percent from federal grants

In SFY 2013, as reported to the legislative sub-committee for Health and Human Resources, DBHDS received \$1.639 billion in revenues for all system operations. CSB ID programs received a total of \$311.2 million dollars in revenue that year:

- 45 percent from fees, including Medicaid fees
- 24 percent was from state General Funds allocated through the CSB Performance Contracts
- 23 percent from localities
- 8 percent from other sources such as workshop sales, retained earnings, charitable donations, grants, and one-time funds

CSB services are also supported, to varying degrees, by annual appropriations from the localities that established them. CSB revenues for ID services include reimbursement for ID services from Medicaid, Medicare, and private insurance; individual co-payments; and other funds such as sheltered workshop sales, retained earnings, charitable donations, grants, and

one-time funds. Neither the number served nor expenditure data specific to CSBs' non-Waiver ID services was available for SFY 2013.

4. Monitoring and Evaluation of (Non-Waiver) ID 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 ID services, offers technical assistance, and oversees protection of human rights. DBHDS additionally is responsible for operational and fiscal oversight, budgeting, allocation of state funds, and quality assurance—not only for the 40 local Community Services Boards (CSBs) but also for the 5 state-operated intermediate care facilities for individuals with intellectual and developmental disabilities (ICFs/IID), known in Virginia as Training Centers. (See the **Institutional Supports** chapter of this *Assessment* for more information on the regional Training Centers.)

The key DBHDS accountability tool is the annual **Community Services Performance Contract**, signed by the DBHDS commissioner and CSB executive directors, which contains numerous data collection and accountability requirements to ensure state/federal regulatory compliance and a quality improvement approach. The **Central Office, State Facility, and CSB Partnership Agreement**, which is part of 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. These documents are available online at <http://www.dbhds.virginia.gov/OCC-default.htm>. Locally, administration of each CSB is further guided by a board of directors consisting of 6 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 OCC 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 by DBHDS staff in each disability area are an important part of 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 and then formal processes, which 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 development, oversight, and enforcement of DBHDS licensure standards, policies, and procedures for providers of treatment, training, and habilitation services for individuals with mental illness, intellectual disability, or substance abuse disorders statewide. These providers include day support, in-home residential, or crisis stabilization services under the Medicaid Home and Community Based Services (HCBS) Individual and Family Developmental Disabilities Support Waiver (DD

Waiver). Licensing staff investigates complaints against providers, which may operate multiple programs or services, and OL staff is required to make at least one unannounced inspection of each provider, each year. OL staff also develops electronic guidance and training materials for providers, which may be purchased; and the staff supplies technical assistance as indicated or requested when staffing allows.

Table 63, covering selected state fiscal years (SFY) between 2007 and 2013 provides a “big picture” regarding the total changes over time in the number of providers, services, and sites for mental health, intellectual disability, and substance abuse. For that period, the number of licensure staff is also listed. Between SFYs 2010 and 2013, Office of Licensure more than doubled its staff after being constant at 15 until SFY 2010. During the same time period, however, the number of providers and services nearly doubled, and the number of locations more than tripled.

Table 63. Number of DBHDS-licensed Providers, Services, and Sites by SFY			
Available Resources	2007	2010	2013
Providers	529	697	844
Services	1,257	1,662	2,038
Locations	2,970	5,037	7,063
Office of Licensing staff	15	15	31

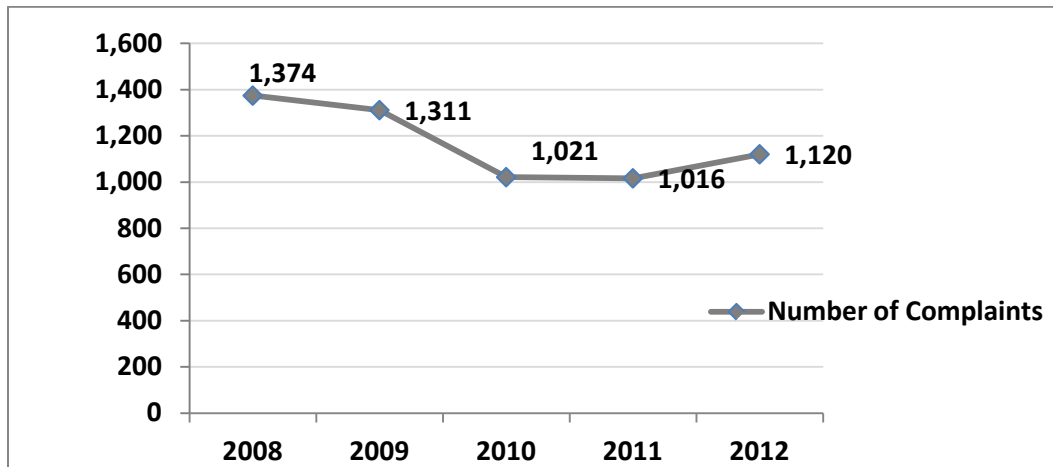
Source: Department of Behavioral Health and Developmental Services, Office of Licensing

Since the 2012 court approval of the DOJ Settlement Agreement, the Office of Licensure has engaged in revising standards and developing performance measures. The Code of Virginia (§ 37.2-418 and 419) was revised in 2012 to establish a range of OL sanctions for non-compliance by providers of residential behavioral health services to adults and youth. Other DBHDS staff concurrently developed a new training curriculum for CSB case managers, which has been implemented. DBHDS is working to strengthen oversight of providers through improved communication between case managers and OL staff.

The **DBHDS Office of Human Rights (OHR)** is responsible for protecting the legal and human rights of individuals receiving services either in state facilities or in the community-based programs operated, licensed, or funded by DBHDS (Code of Virginia, § 37.2-400). The OHR staff monitors provider compliance with relevant regulations, promotes the basic precepts of human dignity, receives and investigates allegations of client abuse and neglect, and provides training on human rights protection and abuse/neglect prevention to individuals with disabilities, family members, providers, and professionals. OHR additionally supports the work of Local Human Rights Committees across the State. OHR staffing has been relatively stable, but increased somewhat in the past 2 years: 19 HR staff in calendar years 2010 and 2011; 21 in 2012; and 22 in 2013.

The OHR posts information on how to make **human rights complaints** or allegations of abuse or neglect on the DBHDS web page at <http://www.dbhds.virginia.gov/OHR-default.htm>. This page includes various reports on the complaints and allegations made as well as OHR activities conducted each year. **Figure 22** depicts the total number of human rights complaints received from individuals in *all* public and private community settings licensed by DBHDS for the period of calendar years (CYs) 2008 through 2012. DBHDS licenses both settings and service providers for intellectual and related disabilities, mental illness, and substance abuse.

Figure 22. DBHDS Human Rights Complaints in Community Settings for CYs 2008–2012



Source: State Human Rights Committee, *2012 Annual Report on the Status of the Human Rights System*, <http://www.dbhds.virginia.gov/documents/reports/OHR-SHRC2012AnnualReport.pdf>.

The number of human rights complaints declined during this 5-year period with the sharpest drop occurring between CYs 2008 and 2010 (353, or 26.9 percent). Thereafter, the number of complaints has been relatively stable, although there was an increase (10.2 percent) between CYs 2011 and 2012.

In 2012, DBHDS contracted with the Social Science Research Center and Old Dominion University to conduct a statewide survey and focus groups of community stakeholders. The study's purpose was to obtain feedback for improvement on various issues related to the human rights complaint processes and local human rights committee (LHRC) role/functions, timeframes, and procedures for abuse/neglect allegations and human rights complaints, among others. The final report, issued in 2013, identified these main areas of consensus:

- The human rights complaint process needs to be simplified (strongest agreement).
- More training is needed on the definition of a complaint and on interpretation of human rights regulations (focus group feedback).
- The timeframe for completion of the initial provider investigation of an abuse/neglect allegation should be no more than 10 days (focus group feedback).

Consumer focus group participants and stakeholder feedback differed on many issues (sometimes substantially). Differences included acceptable reporting timeframes for allegations and the role and functions of the LHRC, among others. The researchers recommended that the Office of Human Rights (OHR) conduct additional dialogues with a wider range of stakeholders statewide to identify other areas of consensus for system and regulatory changes. The report is online at http://www.dbhds.virginia.gov/documents/HumanRights/Compiled_final%20report.pdf.

The OHR additionally reports the number of **abuse and neglect allegations** made and the number of those that are substantiated each year, both from the state Training Centers (detailed in the **Institutional Supports** chapter of this *Assessment*) and from community settings. “Substantiated” means that, after an investigation, the allegation was found to be valid. **Table 64** provides those numbers for calendar years (CYs) 2008 through 2012 for allegations made at all **public and privately operated community programs licensed by DBHDS**. The totals include allegations involving mental health, substance abuse, and ID/DD service providers statewide.

Table 64. Community Program Abuse/Neglect Allegations and Proportion Substantiated by CY					
Calendar year	2008	2009	2010	2011	2012
Abuse/neglect allegations	5,402	6,765	5,710	6,484	6,482
Abuse/neglect substantiated	464	658	508	534	609
Proportion substantiated	8.6%	9.7%	8.9%	8.4%	9.4%

Source: Department of Behavioral Health and Developmental Services.

Although the total annual number of abuse/neglect allegations may seem large, it must be remembered that Community Services Boards (CSBs) served a total of 213,902 unique individuals during SFY 2013. This number includes people who received mental health, developmental, substance abuse, emergency, ancillary, and consumer-run services.

The annual number of abuse/neglect allegations varied, sometimes significantly, between calendar years (CYs): A 25.2 percent increase occurred between CYs 2008 and 2009, followed by a 15.9 percent decline between 2009 and 2010. The number of allegations was relatively stable between CYs 2011 and 2012. A somewhat similar pattern occurred for the annual number of *substantiated* abuse/neglect cases: Between CYs 2008 and 2009, a dramatic increase of 41.8 percent, followed by a sharp decrease (22.8 percent) between CYs 2009 and 2010. Although the number of substantiated cases was stable between 2010 and 2011, another increase (12.2 percent) occurred between CYs 2011 and 2012. Of note, however, is that the proportion of annual abuse/ neglect allegations found to be substantiated since CY 2008 has been relatively stable, ranging from 8.4 percent to 9.7 percent.

Despite the substantial increase in the number of providers, services, and locations in recent years, legislative appropriations for OHR staffing has varied over time. In SFY 2007, OHR had 23.5 advocate positions. Due to state budget cuts during the Great Recession, OHR actually lost positions in 2008 and 2009, dropping down to 19 advocates for SFYs 2009 and 2011. However, the DBHDS and the Commonwealth made a commitment to expand funding for both the Office of Licensing and OHR as part of the Settlement Agreement with the US Department of Justice (DOJ). Three advocate positions were added in 2012, bringing the total to 21 advocates through SFY 2013.

Another oversight resource for all DBHDS services is the **State Office of the Inspector General (OSIG)**, which includes the **Inspector General for Behavioral Health and Developmental Services (IG-BHDS)**. The IG-BHDS monitors and investigates services delivered through all DBHDS-operated facilities, Community Service Boards, and contract providers as well as both mandated provider serious incident reports and citizen allegations of abuse, neglect, or inadequate care by these providers. The IG-BHDS additionally monitors activities and progress regarding implementation of the DOJ Settlement Agreement.

As of January of 2014, the IG-BHDS investigations and follow-up reports released prior to August 2012 are still available online at <http://www.oig.virginia.gov/>. During SFYs 2011 through 2013, new IG investigative reports focused more on mental health services. Specific issues regarding ID/DD community services have been monitored in the past by the Inspector General for DBHDS on an ongoing basis. These include but are not limited to:

- case management services for adults with an intellectual disability at Community Services Boards;
- progress by DBHDS in implementing the priority goals and objectives of the agency's *Creating Opportunities* strategic plan, especially development of a model for a person-centered service planning system and format;
- service gap identification and new service development for persons who have both an intellectual disability and either a concurrent diagnosis of mental illness or significantly challenging behaviors; and
- discharge planning for and community services to individuals who reside/have resided at state Training Centers.

One recent IG-BHDS study (*Report No. 208-12*), however, reviewed progress in the adoption of person-centered practices in community-based residential settings for individuals with an intellectual disability. For seven months, the IG staff examined services statewide in three types of residential settings: Medicaid Waiver group homes; sponsor family homes, and small, non-state Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). The IG found that adherence to the person-centered model varied significantly across settings. Various recommendations were made to make the model a standard of service delivery. (This study is described in more detail in the **Community Housing** chapter of this *Assessment*.)

J. Interpreter and Other Services for the Deaf and Hard-of-Hearing

For individuals of any age who are deaf or hard-of-hearing, sign language interpreters are an invaluable resource in daily communication. Interpreter services (state regulation 22 VAC 20-30-10) is the specific process of facilitating communication using **American Sign Language (ASL)**, a form of manual communication of speech, based on English vocabulary and grammar. An interpreter, trained in ASL, accurately and objectively conveys both spoken and expressive communication between an individual who is deaf or hard-of-hearing and one or more other individuals.

1. Eligibility for VDDHH Interpreter Services

The **Department for the Deaf and Hard of Hearing (VDDHH)** operates two interpreter programs to enhance or ensure access to effective communication in state agencies, the Virginia courts, and in the private sector. The first of these, the **Interpreter Services Program (ISP)**, coordinates sign language interpreters in response to specific requests from state and local government agencies, Virginia courts, and in limited other circumstances. The second program is the **Virginia Quality Assurance Screening program (VQAS)**, which is a diagnostic assessment of the skill levels of sign language interpreters and Cued Speech Transliterators used in credentialing. Screening levels in interpreting and/or transliterating are awarded based on a strict rating process. Screening levels are valid for three years from the date of award.

The Code of Virginia (§ 51.5-113) authorizes VDDHH to coordinate the services of sign language interpreters and Computer Assisted Real-time Translation (CART) for all courts and state agencies, including state colleges and universities. However, VDDHH contracts do not cover interpreters for higher education. Through trained stenographers, CART provides computer or television captioning of spoken language at meetings, for presentations, or webinars. To accomplish that coordination, the VDDHH administers the **Interpreter Services Program** (<http://www.VDDHH.virginia.gov/IpAbout.htm>).

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).

Individuals needing interpreter services to conduct certain Department of Motor Vehicle (DMV) business transactions or to attend 12-Step meetings or funerals may contact VDDHH directly for assistance. VDDHH uses state General Funds to pay for interpreter services at funerals and for one 12-Step meeting per week per person.

For situations in which VDDHH does not coordinate the service, individuals may locate a qualified interpreter through its **Directory of Qualified Interpreters**. This statewide directory, which is maintained by VDDHH, contains contact information for only those interpreters who meet state requirements. A copy of the directory is available on the VDDHH website at <http://www.vddhh.virginia.gov/ipdqi.htm> and also may be obtained by contacting a local VDDHH office.

2. Access to and Use of VDDHH Interpreter Services

Requests for qualified interpreters for persons who are deaf or hearing impaired may be made directly to the Department for the Deaf and Hard of Hearing (VDDHH) by state courts, state agencies and institutions of higher education, local government agencies and legislative bodies, and other public and private organizations across the State. The **VDDHH Interpreter Services Program** directly coordinates the needs of state agencies and colleges, making referrals to contracted sign language interpreters. Agencies requesting services must provide VDDHH with: the name of the individual to be served (if known); the nature of the assignment (specific place, time, and predetermined number of hours); and their billing information. For general (non-court) interpreter requests, the agency pays for the interpreter. Interpreter requests and services for the courts or court-related activities are paid by the Supreme Court of Virginia.

Code of Virginia 51.5-113 requires use of “**qualified interpreters**” by all courts as well as by state and local government agencies. A qualified interpreter must hold one of the following credentials:

- certification from any national organization whose certification process has been recognized by the VDDHH; or
- current screening level awarded by the Virginia Quality Assurance Screening (VQAS) Program of VDDHH; or
- current screening level or recognized credential from another state that is valid, current, and meets the minimum requirements of the VQAS.

Through a Memorandum of Understanding (MOU) with the Supreme Court of Virginia, VDDHH only assigns interpreters who have full national certification for all court and court-related matters.

VDDHH tracks the number of interpreter service requests received from the courts and state or local agencies in each state fiscal year (SFY). In SFY 2010, the agency revised how interpreter requests are processed and counted. In previous years, VDDHH counted multi-date

assignments from a single agency (such as conferences or weekly 12-Step meetings) as separate requests. They now are processed as a single request. In SFY 2010, VDDHH received 2,258 requests for interpreter services; in SFY 2011, 2,474 requests; in SFY 2012, 2,800 requests; and in SFY 2013, 2,460 requests. VDDHH was able to arrange interpreter services for almost every request (at least 99.5 percent) annually.

One limitation, however, is the availability of a sufficient pool of qualified interpreters in the Commonwealth. The pool of available qualified interpreters depends on many factors, including professional mobility, reimbursement rates (which have been flat), and interest in being credentialed. The number of individuals who seek, apply for, or renew the credential of “qualified interpreter” varies by year.

3. Cost and Payment for VDDHH Interpreter Services

VDDHH funding for interpreter services comes primarily from state and federal sources. It receives an annual grant of \$100,000 from a federal special education grant through the state Department of Education to support interpreter services in public schools. State General Fund appropriations provide for interpreter services (including outreach), the Virginia Quality Assurance Screening (VQAS) program, and for agency program administration. VDDHH expenditures for the Interpreter Services Program alone have been as follows: In SFY 2011, \$172,643; in SFY 2012, \$177,112; and in SFY 2013, \$174, 030.

The VQAS program receives approximately 47 percent of its annual budget from state General Fund appropriations. It also collects special revenue from fees through applications for interpreter training and for level screening assessments and re-assessments, which vary each year. In SFY 2011, the VQAS program received \$16,855 in Special Revenues; in SFY 2012, \$16,390; and in SFY 2013, \$18,665. Total expenditures for the VQAS program for the past 3 SFYs are listed in **Table 65**.

State Fiscal Year	2011	2012	2013
VQAS total program expenditures	\$129,857	\$131,754	\$118,444

According to VDDHH, variation exists for both VQAS revenue and expenditures due to the number of contracted raters/diagnosticians (only 32 annually for SFYs 2011 through 2013) and the changing number of individuals seeking assessment or re-assessment each year.

4. Monitoring and Evaluation of VDDHH Interpreter Services

The commissioner and program directors of the Virginia Department for the Deaf and Hard of Hearing (VDDHH) administer and provide oversight of the **Interpreter Services Program**. The VDDHH commissioner must provide performance reports on all programs regularly to the Secretary of Health and Human Resources, the Governor and the General Assembly as required

by law and regulations. As a part of this oversight, VDDHH conducts customer satisfaction surveys and collects program statistics, which are reviewed routinely on an ongoing basis.

Since 1989, the Code of Virginia has charged VDDHH with the responsibility to administer the **Virginia Quality Assurance Screening (VQAS) Program**, which is an assessment and credentialing process for sign language interpreters. The VQAS Program establishes minimum standards and testing/proficiency procedures to be a “qualified interpreter,” which is the employment standard for interpreter services in public schools, courts, and state and local government agencies. Applicants are tested on professional ethics through written assessment and on performance as evaluated by a team of qualified raters. When assessment determines that an applicant meets a VQAS level, the level is awarded and is valid for three years from the date of award. Interpreters may re-test every six months.

The VDDHH VQAS program serves as one credential by which the public can determine the qualifications of a sign language interpreter in the Commonwealth. VDDHH uses the VQAS screening levels as one benchmark for inclusion in the Directory of Qualified Interpreters for participation in its contract for Sign Language Interpreter Services and for employment criterion as a sign language interpreter in Virginia Public Schools.

Sign Language Interpreting, however, is not a regulated profession in the Commonwealth. At the request of the VDDHH Advisory Board, the Department of Professional and Occupational Regulation (DPOR) conducted a study in 2007 to determine if there was need for regulation of the interpreter profession either by registration, certification or licensure. Based on their findings, the DPOR determined that there was not a need to regulate the profession. Because the profession is not regulated, VDDHH does not operate a formal disciplinary or complaint program regarding VQAS-screened interpreters. If the agency does receive a complaint about a VQAS-screened interpreter, VDDHH contacts the interpreter for an informal counseling session to review the Code of Professional Conduct and to discuss ways to address the concerns identified. Because the VQAS is a skills-based diagnostic assessment, VDDHH does not revoke or rescind VQAS screening levels, which are valid for three years from the date of award.

A variety of national certifications, all currently under the auspices of the **Registry of Interpreters for the Deaf, Inc. (RID)**, serve as important credentials for sign language interpreters. RID, the national certifying body has a formal complaint resolution and disciplinary process for RID-certified interpreters. VDDHH refers all callers who have a complaint about a nationally certified interpreter to RID to file a formal complaint. More information on the education and training requirements for RID certification is available online at <http://rid.org>.

K. Omnibus Budget Reconciliation Act Services

The Omnibus Budget Reconciliation Act (OBRA) federal statute (PL 100-203), passed in 1987, is comprehensive legislation that sets legal mandates for the clinical and operational features of all long-term care facilities that seek Medicaid or Medicare certification for funding. At that time, the OBRA bill was the first major revision of federal standards for nursing facility

care since the 1965 creation of Medicare and Medicaid. OBRA requires states to pre-screen all individuals being considered for admission to a Medicaid/Medicare-certified nursing facility through a formal assessment to: (1) determine whether the individual requires that level of services and (2) identify needs, if any, for “specialized services,” whether needed in the community or in a nursing facility. In Virginia, “specialized services” have been defined as services to address a mental illness, an intellectual or related disability, or a substance abuse disorder. (See the **Institutional Supports** chapter for more information about assessments.)

1. Eligibility for OBRA Services

Individuals who receive OBRA assessments, known as the **Pre-Admission Screening and Resident Review (PASRR)**, include anyone being evaluated for eligibility for a potential nursing facility admission as part of long-term care planning. As part of the mandated assessment, a determination must be made of the specialized services needed to maximize the individual’s “highest practical physical, mental, and psychosocial well-being,” self-determination, and independence. After determining whether the individual can benefit from those services, the individual may choose to receive services in the community or in a nursing facility.

Typically, individuals eligible for services under OBRA have a significant disability arising from either a developmental or acquired disability, including but not limited to: intellectual disability, cerebral palsy, epilepsy, autism, brain or spinal cord injury, muscular dystrophy, multiple sclerosis, spina bifida, stroke, or other conditions of neurological origin. As required by federal law (Developmental Disabilities Act of 2000), a developmental disability is a severe, chronic disability (physical, cognitive or a combination of both) that manifests prior to age 22, is likely to persist indefinitely, and results in significant impairment in three or more activities of daily living.

All eligible individuals under OBRA can receive comprehensive assessment and evaluations for specialized services that are *not* covered by the Medicaid State Plan option. DBHDS contracts with a private vendor to conduct the assessments as well as with the Department for Aging and Rehabilitative Services (DARS) and local Community Services Boards (CSBs) for distribution of the funds covering the identified services.

DARS rehabilitation specialists in the Community Rehabilitation Case Management (CRCM) Services staff, who work out of DARS field offices or local CSBs, provide or coordinate these services. CRCM staff additionally works with residents of nursing facilities who wish to transition from the institution to a community setting. DARS Community rehabilitation specialists work with social workers, Centers for Independent Living (CILs), and other resources to ensure that those eligible for OBRA receive services appropriate to their individual needs as well as to their choices about where they will live. These decisions, however, are typically influenced by the availability of housing and community supports available through the Medicaid Home and Community Based Services (HCBS) Waivers or other sources.

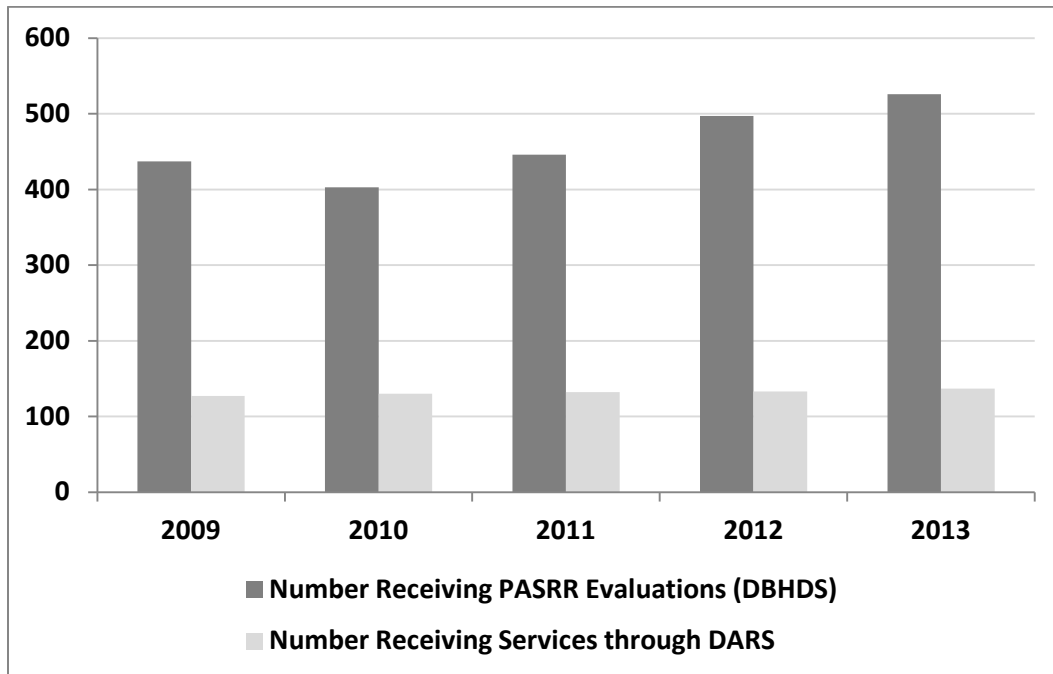
In most cases, support coordination by a CRCM rehabilitation specialist can be continued if an individual is not receiving case management through a Medicaid HCBS Waiver or other program, but OBRA funding for that support does not extend beyond the one-year transition period. In recent years, OBRA has increased transition assistance for individuals who leave a nursing facility on their own or with assistance from the Money Follows the Person (MFP) program. Transition assistance includes various supports such as home modifications, deposits for utilities, rehabilitation engineering, transportation to service providers, and assistive technology.

2. Access to and Use of OBRA Services

In Virginia, OBRA requirements are collaboratively fulfilled by the Department of Medical Assistance Services (DMAS), the Department for Aging and Rehabilitative Services (DARS), and the Department of Behavioral Health and Developmental Services (DBHDS). DBHDS is administratively responsible for the Pre-Admission Screening and Resident Review (PASRR), and for determination of specialized service needs as well as provision or arrangement for delivery of those services. Once an individual qualifies for OBRA services, DBHDS staff conducts subsequent, targeted Resident Reviews at various time intervals, the frequency of which are determined by each individual's profile of needs. Both the PASRR and Resident Reviews include documentation of each individual's current capacity to transition to a less restrictive environment or to the community. (Information on OBRA is available on the DBHDS website at <http://www.dbhds.virginia.gov/omh-OBRA.htm>.)

The services most commonly requested and used by eligible individuals 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. Individuals generally also receive personal assistance services along with other services as needed and appropriate. **Figure 23** depicts the annual total number of individuals who received assessments through DBHDS or services from DARS under OBRA for the past five state fiscal years (SFYs). The DARS counts do not include individuals referred whose cases were closed because they left a facility, could not benefit from services, or died during the year.

Figure 23. Number of Assessments and Individuals Served under OBRA by SFY



Between SFYs 2009 and 2013, the number of individuals receiving PASRR evaluations through DBHDS increased by 16.9 percent (an additional 89 individuals). By contrast, the number of individuals receiving OBRA services through DARS has been relatively stable, declining by 7.3 percent (10 individuals).

3. Cost and Payment for OBRA Services

Funding for OBRA assessments and services is from federal and state monies. During the contract period of February of 2013 through January 31, 2014, the DBHDS paid its contractor \$418,994 to conduct nursing facility Pre-Admission Screening and Resident Reviews (PASRR). Of that amount, 75 percent was billed to and reimbursed by DMAS through a Memo of Understanding (MOU); and the remaining 25 percent (Virginia’s “state match”) was paid through state General Funds allocated to DBHDS. The annual amounts budgeted to DARS to provide services under OBRA for SFYs 2009 through 2013 are listed in **Table 66**.

State Fiscal Year	2009	2010	2011	2012	2013
Budget for DARS OBRA Services	\$509,509	\$388,731	\$416,989	\$486,700	\$404,000

According to DARS staff, the average per person expenditure varies, sometimes significantly, based on the particular services needed by the individuals who are eligible that year. One-time expenditures for specialized equipment such as motorized wheelchairs or

communication devices can be as high as \$15,000 to \$25,000. From SFY 2009 through 2013, the average OBRA expenditure ranged from \$3,000 to \$4,000 per person.

4. Monitoring and Evaluation of OBRA Services

The Virginia **Department of Behavioral Health and Developmental Services (DBHDS)** monitors and provides oversight for assessments conducted by its contracted vendor. DBHDS contracts with the **Department for Aging and Rehabilitative Services (DARS)** to monitor and provide oversight of compliance with federal regulations by providers of OBRA services to eligible individuals. DARS consults with its DBHDS liaison on an ongoing basis about its findings. Customer comments are routinely documented and concerns by DARS staff are forwarded to the appropriate rehabilitation specialist, program coordinator, and division director as needed. All activities and expenditures must comply with guidelines set forth by the federal Centers for Medicare and Medicaid (CMS); DBHDS annually provides reports on OBRA activities and expenditures to CMS.

L. Personal Assistance Services (Non-Medicaid Waiver)

Under Virginia Administrative Code 22 VAC 30-20-10, **personal assistance services (PAS)** are a range of *non-medical* supports provided by one or more persons who assist an individual with a disability in performing **activities of daily living (ADLs)** that they themselves cannot do because of their impairment either “on or off the job.” ADLs are bathing, dressing, toileting, eating, and bowel or bladder control (12 VAC 5-381-10). PAS may include training to assist the individual with a disability in “managing, supervising, and directing” such services. Personal assistance services (PAS) must be (1) designed to increase autonomy and self-determination, (2) necessary to the achievement of an employment outcome, and (3) may be provided only while the individual is receiving other vocational rehabilitation services. Individuals with such limitations who receive vocational rehabilitation services may also receive personal assistance services (known as **VR-PAS**) through the **Department for Aging and Rehabilitative Services (DARS)**.

In addition, through DARS policy and the annual state appropriations bill, PAS are made available through two programs to additional groups when no other source of personal assistance services is a viable option: the **State-funded PAS program** (non-Medicaid PAS for individuals with significant disabilities) and the **PAS for Individuals with Brain Injury (PAS-BI) program**.

1. Eligibility for (Non-Waiver) PAS

General eligibility requirements for the State-funded (but non-Medicaid) PAS program are that an individual (1) has a significant physical disability (regardless of cause), and, (2) based on a formal determination, does not have financial resources above a set limit, and (3) does not qualify for PAS under public insurance (Medicare, Medicaid, or a Medicaid Waiver), private insurance, or any other public program. For PAS-BI, eligibility also requires (1) an assessment of

the brain injury made by a qualified professional, and (2) that the individual have a representative who will manage the services.

For each of the three PAS programs (VR, non-VR, and Brain Injury PAS), an individual must submit an application, which is available online or upon request by phone. For more information on eligibility, individuals can contact PAS staff within the DARS Division of Community Based Services by calling the following numbers toll-free 800-552-5019 or (TTY) 800-464-9950, or by going online to <http://www.vadrs.org/cbs/pas.htm>.

2. Access to and Use of (Non-Waiver) PAS

After the individual has submitted an application for personal assistance services, DARS staff in the Division of Community Based Services conducts an assessment of both the individual's service needs and of his or her eligibility for comparable services from any other source. If the individual is found eligible for services under vocational rehabilitation (VR-PAS), DARS staff provides information and referral to help an individual obtain those services. Based on an individual's ability or choice, the VR-PAS may be provided either as a consumer-directed option (whereby the client is the "employer of record" for IRS and management purposes) or as an agency-directed option.

Being solely reliant on state General Funds, the State-funded PAS and the PAS-BI are available to a limited number of individuals each year. Additional funding is available when either the state legislature increases the annual appropriation or an individual discontinues PAS because alternative funding was obtained. When funds become available, DARS staff conducts assessments for each applicant, and selection of individuals for services is based on severity of need.

Both **State-funded PAS and PAS-BI programs** are only available as **consumer-directed services**. As with consumer-directed PAS offered through the Medicaid Home and Community Based Services (HCBS) Waivers described in the **Medicaid** chapter, the individual with a disability recruits and hires a **personal assistant (PA)**, provides training to the PA, establishes work schedules and duties, directs the PA's work, authorizes timesheets for payment, and terminates the PA if necessary. Those eligible for PAS-BI must have a designated representative to either assist with or perform these responsibilities. To learn more about handling these responsibilities effectively, the individual with a disability must participate in PAS orientation training.

At this time, Virginia does not have a credential or certification program for personal assistance providers. Through grant funding, the **Virginia Association of Centers for Independent Living (VACIL)** established a directory that allows both those looking for a personal assistant and individuals seeking such employment to self-identify themselves. As a result of this project and collaboration with the Department of Medical Assistance Services (DMAS), in 2011 the Public Partnership Limited (PPL), a fiscal agent of DMAS, assumed the maintenance for the online directory. The lists (available at

<https://connect.publicpartnerships.com/LoginASD.aspx>) are generated by individuals. As noted on the website, PPL does not conduct any background or reference checks on individuals seeking employment. PPL is not responsible for verifying or examining the accuracy of any information provided online. Consumers and family members have expressed concern regarding the utility of the directory and indicate that it is not user friendly.

DARS 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. DARS also reviews personal assistant (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 DARS review and approval of timesheets, verification of employment and earnings, and payroll preparation, a contract payroll provider handles payments, taxes, and earnings reports.

The numbers of persons either receiving PAS through DARS or on the waiting list for PAS at the end of each state fiscal year (June 30) for 2007 through 2013 are listed in **Table 67**. Of the three PAS programs, only the VR-PAS does not have a wait list because it is mandated through federal vocational regulations and funding.

Table 67. Number Served and Number on Waiting Lists for DARS Personal Assistance Services by SFY							
PAS Program	2007	2008	2009	2010	2011	2012	2013
PAS/Brain Injury							
Number served	6	6	5	5	5	7	7
Number on waiting list	2	2	3	3	3	2	3
State-funded PAS							
Number served	168	155	155	122	163	160	177
Number on waiting list	54	40	40	94	82	69	41
VR-PAS							
Number served	62	31	35	45	22	22	20

Source: Department for Aging and Rehabilitative Services, Division of Community Based Services.

Over this time period, the number of individuals served under PAS-BI and State-funded PAS has been relatively stable, which reflects each program's capacity resulting from individual needs and available state funds. Between SFYs 2009 and 2010, however, the number waiting for State-funded PAS increased dramatically and remained high until SFY 2013. The State-funded PAS program served 9 more individuals in SFY 2013 than in SFY 2007, an increase of 5.4

percent. The number served under VR-PAS fell by 50 percent between SFYs 2007 and 2008, and has remained low as compared to SFY 2007 due to the recession and weak job growth.

3. Cost and Payment for (Non-Waiver) PAS

While the VR-PAS program is federally funded through Title 1 of the Rehabilitation Act, both the PAS-BI and State-funded PAS are solely reliant on legislative appropriations of state General Funds. **Table 68** lists the total annual expenditures for each PAS program through the Department for Aging and Rehabilitative Services (DARS). As the expenditure data indicate, the level of funding has declined for each PAS program, in part due to the slow economic recovery, which impacts state revenues (PAS-BI and State-funded PAS) and available federal funds (VR-PAS).

DARS PAS Program	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2013
PAS/Brain Injury	N/A	\$77,659	\$52,217	\$64,569	\$69,673
State-funded PAS	\$2,145,345	\$2,276,131	\$1,950,952	\$1,984,803	\$1,965,819
VR-PAS	\$604,547	\$511,417	\$547,466	\$436,364	\$307,840

4. Monitoring and Evaluation of (Non-Waiver) PAS

The State-funded PAS and PAS for Individuals with Brain Injury (PAS-BI) are overseen by both a program manager and the director of the Community Based Services Division of the Department for Aging and Rehabilitative Services (DARS). DARS staff conducts internal record reviews and program audits to identify areas for improvement such as program policy updates or operational issues. A PAS Advisory Committee—comprised of individuals with disabilities, representatives from Centers for Independent Living (CILs), and agency staff—meets quarterly to review each program and make additional recommendations for improvements. Feedback is also obtained through consumer satisfaction surveys and contacts with individuals served, their families and personal assistants, and the local Centers for Independent Living (CILs).

The same oversight is provided by DARS for the VR-PAS program. However, federal law requires that DARS additionally prepare and submit an annual report to its federal funding source, the Rehabilitation Services Administration.

M. Services for the Elderly Population

While many state agencies provide disability services across the lifespan, three programs specifically serve Virginians who are elderly:

1. The **Public Guardian and Conservatorship Program** is administered by the Virginia Division for the Aging (VDA), within the Department for Aging and Rehabilitative

Services (DARS). VDA is responsible for oversight of state programs or services specifically funded through the federal Older Americans Act (as amended PL 109-365) and through certain related appropriations by the Virginia General Assembly. Although an independent state agency until July of 2012, VDA now, as in the past, coordinates and administers services to the elderly through contractual partnerships with local Area Agencies on Aging (AAAs).

2. The **Older Blind Grant Program** is administered by the Department for the Blind and Vision Impaired (DBVI).
3. The **Program of All-inclusive Care for the Elderly (PACE)**, an optional Medicaid State Plan service, is funded and administered by the Department of Medical Assistance Services (DMAS).

Each of these programs has somewhat different eligibility criteria, access procedures, and services due to the purposes and functions established under its funding authorization. Services are organized here by state agency with information on eligibility, types of services, service access and availability, costs and funding for services, and how they are monitored and evaluated.

1. DARS' Virginia Division for the Aging

Within the Department for Aging and Rehabilitative Services (DARS), the Virginia Division for the Aging (VDA) contracts with 25 **Area Agencies on Aging (AAA)** to provide services to the elderly. The AAAs may be any one of the following entities, and this list includes the number of each in 2013:

- 14 were private or nonprofit organizations;
- 5 were joint exercise-of-powers agency;
- 5 were part of a government unit; and
- 1 was a Community Services Board (CSB).

Each AAA is required to develop and provide services that address the needs of the target populations in its geographic service area(s). In addition, VDA administers funds through contracts for the **Virginia Public Guardian and Conservatorship Program**, which is a resource “of last resort” for legal guardians for those with a documented need for such assistance.

a. Eligibility for and Available VDA Contracted Services

Through contracts with VDA, each Area Agency on Aging (AAA) offer information, referrals, and technical assistance to locate and obtain available services to anyone in their service area who is either (1) age 60 or over, or (2) has a serious disability and is 18 through 59 years old. The same services are available to family members, caregivers, and/or guardians of these individuals at AAA offices statewide.

To receive any **direct service** from an AAA, individuals must be **age 60 or over**. Priority for AAA services is given to older individuals who are in the greatest socio-economic 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.

Two exceptions for age eligibility are services provided through the **National Family Caregiver Support Program (NFCSP)** and the **Title V Senior Community Service Employment Program**, which are both open to those who are **age 55 or over**. The employment program is available only from a few AAAs. Family members themselves are eligible for services under the **NFCSP** if they are (1) adult caregivers of individuals who either are elderly or are under age 50 with early onset dementia, or (2) are themselves age 55 or over and are caring for a child or adult up through age 59 who has a severe disability.

Although the scope and type of services may vary depending on area needs, the following are common services provided by the AAAs:

- information and referral, communication, and assistance;
- service coordination;
- meals and nutrition services (delivered in homes or at program sites);
- transportation;
- in-home (chore or homemaker services) and caregiver support services;
- health and wellness information and screenings;
- options counseling (to help determine how and where to meet long-term care needs); and
- elder abuse prevention.

Some AAAs also operate senior centers, which offer recreation and social activities as well as assistance in completing applications for services or tax filing, and/or adult day centers to provide daily supervision and activities for older adults who cannot stay at home alone safely all day. A few AAAs administer housing programs for older residents, operate comprehensive transportation systems, or operate a Program of All-inclusive Care for the Elderly (PACE) center. Many AAAs provide benefit counseling for Medicare beneficiaries and others through the Virginia Insurance Counseling and Assistance Program (VICAP). In addition, many AAAs operate the local **Long Term Care Ombudsman program**, which provides advocacy for older persons who receive long-term care services (whether in nursing facilities, licensed adult homes, or community-based settings) as well as investigates and resolves complaints made by (or on behalf of) these older persons.

Administered under contract with the VDA, the Virginia **Public Guardian and Conservator Program** was established under § 51.5-149 et seq. of the Code of Virginia. This program funds

local human service agencies to provide guardianship services for any person aged 18 and over (not just the elderly) for whom all three of the following apply:

1. have been legally determined to be unable to care for themselves or to make decisions about their care or finances (are “incapacitated”);
2. are found to be financially indigent; and
3. do not have a suitable person willing or able to serve as their decision-maker.

Information on this program and guardianship procedures is online at <http://www.vda.virginia.gov/guardboard.asp>.

b. Access to and Use of VDA Services

The **Virginia Division for the Aging (VDA)** is responsible for coordination of services provided by the independent **Area Agencies on Aging (AAAs)** and other contractual partners. VDA serves as both an educational and outreach resource on aging issues and acts as a central referral agency for direct services provided by the 25 AAAs and 19 other community-based organizations.

For several years, the VDA has been active in the federal initiative, Aging and Disability Resource Connections (ADRC). Its purpose is to help all individuals who are looking for services—either for themselves or a family member—to locate them more easily through a “virtual” single point of entry. Virginia’s initiative, called **No Wrong Door**, has developed statewide partnerships with other state agencies, professional associations, disability advocacy groups, local governments, and private and nonprofit community organizations that provide services to citizens who are elderly or have a disability.

The local No Wrong Door network of public and private agencies can access a database to locate needed services for individuals as well as eliminate duplicative application forms and streamline eligibility determinations. The network can also share up-to-date client information to make referrals between agencies faster and easier, to better coordinate services, and to improve tracking of outcomes. The No Wrong Door website is at <http://www.vda.virginia.gov/nowrongdoor.asp>.

This evolving model relies heavily on interagency cooperation and coordination among the participating service providers. In partnership with **SeniorNavigator**, a 501c(3) nonprofit organization, leadership within the VDA and the Department for Aging and Rehabilitative Services coordinate and provide technical assistance to all participating organizations and establishes the protocols to ensure that providers’ and their clients’ privacy is protected and that information is shared only with their consent. The AAAs, with assistance from Advisory Councils, coordinate No Wrong Door with community partners in their localities.

VDA also manages an online information service that includes information on services and topics for adults who are elderly or have a disability. Created to be user-friendly and available

24/7, **Virginia Easy Access** is a search engine for locating services anywhere in the State. It is a virtual gateway to **VirginiaNavigator**, which lists over 21,000 programs and services statewide, and to the 2-1-1 Virginia Call Center, which provides referral assistance by phone. Each of these resources is free to use, confidential, and available to the general public. **Virginia Easy Access** is at <http://www.easyaccess.virginia.gov>.

Although “walk-ins” may occur, the Area Agencies on Aging (AAAs) typically receive requests for information or for services by phone and then follow-up with a person-to-person assessment, as indicated. Services vary by region or locality, since AAAs develop and deliver services based on the needs of the geographic area that each serves. Through its **No Wrong Door** initiative, and with individual consent, AAAs can enter an applicant’s information into a shared, confidential electronic database to expedite their application for and receipt of services as well as to coordinate services.

Since state fiscal year (SFY) 2010, when participation reached a peak, the number of individuals receiving services through the AAAs has been declining. **Table 69** lists the number served from SFYs 2008 through 2013.

Table 69. Number Served by Area Agencies on Aging by SFY						
State Fiscal Year	2008	2009	2010	2011	2012	2013
Number served	57,835	59,045	63,303	58,487	54,283	53,831

Source: Department for Aging and Rehabilitative Services, Division for the Aging

The total number served through the AAAs peaked in SFY 2010 and declined thereafter annually. Between SFYs 2011 and 2013, the number of elderly served by AAAs declined by 8.9 percent (5,186 individuals). According to the Virginia Division for the Aging (VDA) staff, local funding for AAAs decreased during the recession (SFYs 2008 through 2010); and federal American Recovery and Reinvestment Act of 2009 (ARRA) “stimulus funds” were available in SFYs 2010 and 2011, enabling more people to receive services. Some local and federal funds were decreased as a result of budget cuts under the sequestration bill in SFY 2013. Waiting lists have been maintained by some local programs where the number of service requests exceeded the number of people for which the AAA was contracted to serve.

With respect to the **Virginia Public Guardian and Conservator Program**, initial identification of individuals who need assistance, regardless of age, is made by staff at local adult care facilities, the Adult Protective Services divisions of local social services departments, hospitals, and other service organizations that serve persons who are elderly, have a disability, and/or are indigent. The referring agency forwards relevant information about the individual’s functioning to a multi-disciplinary panel of the local guardianship program, which determines eligibility. Once an individual is determined to be eligible, 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 Circuit Court 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, the judge has flexibility in establishing the type of guardianship or conservatorship to preserve as much of the individual's independence as possible. A time-limited guardian or conservatorship may be established by the court on an emergency or temporary basis while decisions that correct the conditions causing the emergency are implemented or made to address specific issues that place an individual at-risk, such as medical or monetary matters. A standby guardian can also be designated by the court to assume that role after the death of a person who was responsible for the care of someone determined to be incapacitated.

When court approval is given, the local guardianship program takes responsibility for the person who is incapacitated and acts on his or her behalf consistent with the specific tenets set forth by the court and state law. An individual who was determined "incapacitated" 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, upon formal request, the judge may appoint another person or entity to be guardian or conservator.

Other legal alternatives to guardianship and conservatorship available 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.

The **Virginia Public Guardian and Conservator Program**, which relies on state appropriations, historically has had limited service capacity. This program is not available in all areas of the State: programs do not exist at all in Southwest and Southside Virginia. Based on available funds and cost projections, the Virginia Division for the Aging (VDA), which administers the program, designates a maximum number of individuals who can be served annually by each local guardianship program. Since SFY 2008, this program served up to a maximum of 601 individuals each year. Of those served annually, services to 307 individuals are funded through state General Funds; and services to another 294 individuals who have a mental health or intellectual disability are funded through the Department of Behavioral Health and Developmental Services (DBHDS). All local programs stay at or near capacity, and some have maintained waiting lists.

The *2014 Biennial Report on the Virginia Public Guardian and Conservator Program* noted that there were 891 individuals documented on program waiting lists statewide who need Public Guardian services. Of that number, 580 individuals could be served immediately if state funds were allocated to do so. A 2007 study by the Virginia Tech Center for Gerontology projected that over 1,200 individuals statewide have unmet needs for guardian services.

c. Cost and Payment for VDA Coordinated/Contracted Services

The Virginia Division for the Aging receives over 60 percent its annual budget from the **US Administration on Community Living** in support of the Older Americans Act (OAA); additional federal funds come through the US Department of Labor (employment services), the federal Centers for Medicare and Medicaid (CMS), or competitive federal and other grant programs. Legislatively appropriated state General Funds must be provided as “match” for any OAA funds or federal grant awards, which primarily apply to the following:

- community-based services;
- transportation services;
- home-delivered meals;
- care coordination services;
- the No Wrong Door initiative, including SeniorNavigator; and
- VDA administration.

The VDA annually distributes funding to the Area Agencies on Aging based on a formula that was jointly developed by the Division and the AAAs. Funding details on services to the elderly by source are provided in the VDA five-year plan, *Virginia’s State Plan for Aging Services, October 1, 2011–September 30, 2015*, which is posted on its website at <http://vda.virginia.gov/pdfdocs/StatePlanForAging2011-2015.pdf>. The Public Guardian and Conservator Program is solely funded by state General Funds.

The VDA 2011–2015 state plan points out that federal funding, with the exception of the one-time federal ARRA stimulus funds in 2009 and 2010, has not kept up with inflation. Rising fuel costs have negatively impacted in-home meal delivery and transportation services to the elderly, in particular. With the first “baby boomers” turning 65 years old in 2011, the demand for public services is likely to continue to increase along with the growing number of elderly “boomers.” 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 an individual’s ability to pay.

Table 70 lists the expenditures for each VDA program for SFYs 2009 through 2013.

Table 70. VDA Expenditures for Services to the Elderly by SFY					
Program/Service	2009	2010	2011	2012	2013
AAA Contracts	\$52,709,018	\$53,570,233	\$51,951,039	\$52,948,655	\$49,747,106
Public Guardianship	\$1,869,645	\$2,040,600	\$1,954,950	\$1,993,332	\$1,993,550

Expenditures for contract services with the AAAs have varied somewhat. In SFY 2013, expenditures dropped to their lowest level of the five-year period. Expenditures for the Public Guardian and Conservatorship Program, with the exception of 2010, were relatively flat over these years.

d. Monitoring and Evaluation of VDA Contracted Services

The **Virginia Division for the Aging (VDA) within DARS** is legally designated as the State's "unit on aging" by the federal Office of Administration on Aging. This designation charges the VDA to provide funding, planning, coordination, technical support, and oversight of all programs funded through the federal Older Americans Act. Federal law requires VDA to conduct periodic needs assessment of older Virginians to determine the extent to which public and private programs meet those needs. Programs for the elderly under VDA oversight are those operated by the local Area Agencies on Aging (AAAs) and other contractual partners. Under Code of Virginia § 51.5-135, VDA is charged to

act as lead state agency ... for research, policy analysis, long-range planning, and education on aging issues.

VDA develops and monitors quality standards of services to the elderly provided through the AAAs or other contractors. Service standards, which are posted on the VDA website, cover recordkeeping, appeals processes, federal and state legal requirements, use of the Uniform Assessment Instrument (UAI), and other program-specific matters. VDA conducts fiscal and program reviews of the AAAs and other contractors; and provides onsite technical assistance when needed. When deficiencies are noted, program providers may be required to prepare and implement corrective action plans.

VDA also provides staff support for three state advisory boards/councils on issues faced by the elderly population and on the programs that it administers:

1. The **Commonwealth Council on Aging** is a statewide citizens group that promotes efficient, coordinated planning and services by state government to meet the needs of older Virginians. (See Code of Virginia §§ 51.5-127 and-128 for full duties.)
2. The **Alzheimer's Disease and Related Disorders Commission** is an advisory group that makes recommendations for funding, statutory or regulatory changes, and other issues to the state Secretary of Health and Human Services. (See Code of Virginia § 51.5-154 for full duties.)
3. The **Virginia Public Guardian and Conservator Advisory Board**, as authorized by Code of Virginia § 2.2-2411, provides technical assistance and advises VDA staff in the coordination, management, and oversight of local guardianship programs. It also advises the VDA commissioner on policies and issues. Members of each board/commission are appointed by the Governor and General Assembly.

During 2014, as it has done previously, the **Commonwealth Council on Aging** will hold a series of “listening” sessions, called Community Conversations on Aging, to gather information on the availability and quality of services in various regions. The discussions have been used to inform the development of policy recommendations. The 2014 listening session will be held at: Charlottesville, Newport News, Richmond, Roanoke, and Woodbridge (Prince William area). A report of these meetings will be published.

In SFYs 2010 and 2011, VDA conducted extensive monitoring of all local **public guardianship programs**, reviewing at least 80 percent of client records at each local program. The reviews were made to ensure compliance with state law and Circuit Court orders as well as to establish baseline performance measures. VDA now annually conducts on-site monitoring of all programs, which includes client record reviews of a randomly selected sample.

The **Virginia Department for Aging and Rehabilitative Services (DARS)** has statutory responsibility (Code of Virginia, 51.5-135) for either providing or contracting for the administration of Virginia’s **Long-Term Care Ombudsman Program**. DARS administers and operates this program but contracts with local **Area Agencies on Aging (AAAs)** to provide Ombudsman services. The ombudsman program receives, investigates, and works to resolve complaints made by or on behalf of older Virginians regarding long-term care services provided by state or local public agencies, contractual providers, or private nonprofit or for-profit entities. Long-term services may be located in institutions (nursing facilities, assisted living facilities, long-term care hospitals) or community-based outpatient programs. However, only a small percentage of cases (1 to 2 percent) annually have been based in community programs through SFY 2013. To ensure coordinated statewide access, the DARS operates a toll-free hotline for information and referrals. As part of its quality assurance, VDA requires Ombudsman program staff to complete a certification curriculum. (More information on this program is included in the **Institutional Supports** chapter of this *Assessment*.)

2. DBVI’s Older Blind Grant Program

a. Eligibility for and Available OBG Program Services

The Department for the Blind and Vision Impaired (DBVI) administers the federally funded Older Blind Grant (OBG) Program for Virginia residents **ages 55 and over** who have documented blindness or a severe visual impairment that significantly interferes with normal life activities. Many of the seniors referred to the OBG program have either become blind or experienced a significant vision loss late in life, which threatens their personal independence. DBVI program staff provides free assessments, one-on-one training, and instructional services for all individuals; however, financial need criteria must be met for coverage of costs associated with services such as the provision of adaptive equipment for individuals who are blind or vision impaired. The program web page is at <http://www.afb.org/info/programs-and-services/professional-development/experts-guide/older-blind-grant-program/1235>.

The OBG program offers a wide variety of essential supportive services for independent functioning in the home and community:

- outreach,
- information and referral,
- advocacy,
- visual screening,
- eyeglasses and low vision aids,
- assistance with housing relocation,
- adaptive equipment,
- guide and orientation services to improve mobility and self-sufficiency,
- transportation,
- peer counseling,
- volunteer reader services, and
- adaptive skills training for daily living activities.

Program staff additionally conducts local independent living training workshops, as needed, for consumers and their family members.

b. Access to and Use of OBG Program Services

To obtain information or services from the Older Blind Grant (OBG) Program, older Virginians or their family members can contact any one of the agency’s six regional offices or call its toll free number: 800-622-2155. Regional offices are located in Bristol, Fairfax, Norfolk, Richmond, Roanoke, and Staunton. Staff will explain the available services and the visual and financial need eligibility requirements, assist with service applications, and make referrals to specific DBVI programs or other community resources, as appropriate.

Table 71 lists the number of seniors (ages 55 and older) served through the DBVI’s OBG program for state fiscal years (SFYs) 2010 through 2013. Data prior to SFY 2010, which were based on broader guidelines, are not comparable because of changes to the reporting requirements made by the US Rehabilitative Services Administration beginning that year.

Table 71. Number Served by the Older Blind Grant Program by SFY				
State Fiscal Year	2010	2011	2012	2013
Number served	1,602	1,890	1,756	1,694

Source: Department for the Blind and Vision Impaired.

Program capacity has varied over time, largely due to funding levels and the service needs of the individuals referred to the OBG program. Budget cuts (both state and federal) have occurred since 2008—with the brief exception of added federal ARRA stimulus funds in 2010 and 2011. The SFY 2014 budget also had a 5-percent cut as a result of the 2013 federal sequestration. According to DBVI, since SFY 2007 the number of private providers available to serve individuals with significant vision impairments increased, thereby reducing the number of referrals to the OBG program. Between SFYs 2010 and 2013, the number served under the Older Blind Grant program increased by 5.7 percent (92 seniors). However, compared to the peak in SFY 2011, the number of seniors served in SFY 2013 declined 12.2 percent (196 seniors). DBVI has implemented various outreach strategies to better inform optometrists, ophthalmologists, and other eye care professionals about services available through this program.

c. Cost and Payment for OBG Program Services

The Older Blind Grant program receives funding for services to seniors through a federal grant program called Independent Living Services for Older Individuals who are Blind, which is administered by the US Office of Special Education and Rehabilitative Services. A grant “match” must be provided annually through state General Fund appropriations. Salaries for rehabilitation teachers serving seniors in the OBG program are funded through both federal and state funds. Annual expenditures for the Older Blind Grant program over the past three SFYs have been as follows:

- \$388,792 for SFY 2011;
- \$279,476 for SFY 2012; and
- \$295,255 for SFY 2013.

The increase in OBG program expenditures in SFY 2011 was attributed to added federal stimulus funds provided by the ARRA.

d. Monitoring and Evaluation of OBG Program Services

The DBVI commissioner and program director are responsible for program administration and oversight. The regional DBVI offices send data collected on services provided, number served, outcome measures, and expenditures to the administrators for review. Outcomes include customer and family feedback on service impact from satisfaction surveys as well as federal measures of improved independent functioning. As required by statute, the DBVI commissioner reports performance indicators on this and all other programs to the Secretary of Health and Human Services, the Governor, and the legislature. Reports are posted on the Virginia Performs website at <http://www.vaperforms.virginia.gov>.

On a quarterly and annual basis, the DBVI commissioner additionally is required by federal mandate to provide performance reports to two other entities. One entity is the **DBVI State Rehabilitation Council (SRC)**, a federally mandated advisory group focused primarily on services

to those who are either employed or in the DBVI vocational rehabilitation program. SRC members are appointed by the Governor, and a majority of members are individuals who are blind or visually impaired. DBVI also must file an annual programmatic and fiscal report regarding the Older Blind Grant Program to its funding source, the **US Rehabilitative Services Administration (RSA)** under the Office of Special Education and Rehabilitative Services. Both SRC meeting minutes and the annual federal program reports can be found on the DBVI website at <http://www.vdbvi.org>.

3. DMAS' Program of All-inclusive Care for the Elderly (PACE)

The **Program of All inclusive Care for the Elderly (PACE)** is an optional Medicaid State Plan service that specifically targets Virginians who are elderly and Medicaid eligible. PACE is funded through and administered by the state **Department of Medical Assistance Services (DMAS)**.

a. Eligibility for and Available PACE Services

PACE provides care coordination of the entire continuum of medical care and supportive services needed by Virginians ages 55 and over in order to: remain in their own or family homes, and

maintain self-sufficiency and preserve the highest level of physical, social and cognitive function, and independence.

To be eligible for PACE, state regulations (12 VAC 30-120-63) specify that an individual at the time of application must meet all of the following requirements:

1. be 55 years or older;
2. be eligible for or enrolled in the Medicaid and/or Medicare insurance programs;
3. meet level of care criteria for a nursing facility or, if an individual with an intellectual disability, meet the level of care of an intermediate care facility for persons with an intellectual disability (ICF/IID);
4. reside in the geographic service area of a PACE organization;
5. have his or her health, safety, and welfare "assured in the community;" and
6. meet any other criteria used by the local program.

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 (see Code of Virginia § 32.1-330 for full description). Screenings must be conducted by staff from (1) the local Department of Social Services together with the local Department of Health or (2) a hospital from which the individual is being discharged.

Generally, individuals who are eligible for Medicaid or Medicare are eligible to enroll in PACE. Individual income must be equal to or less than 300 percent of the current year's

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. PACE also accepts otherwise eligible individuals who desire to participate and will pay for the services out of private funds.

b. Access to and Use of PACE Services

Referrals to a PACE provider may be from the individual, a family member, caregiver, or a human service professional or agency on behalf of the individual. Services are provided by designated agencies under contract with the **Department of Medical Assistance Services (DMAS)**. Begun in November 2007, PACE has gradually expanded from 6 to 14 locations across the State. DMAS provides a current list of PACE providers, locations, and contact information online at http://dmasva.dmas.virginia.gov/Content_pgs/ltc-pace.aspx. During 2013, 8 PACE providers offered services in the 14 locations listed by region below.

- Tidewater
 - Sentara Senior Community Care (SSCC) has two sites; one serves the Portsmouth area, and the other serves the Virginia Beach area.
 - Riverside PACE has two sites; one serves the Newport News area, including parts of York County, and the other serves Hampton Roads, including Poquoson.
- Capitol Area
 - Riverside PACE has three sites; two sites serve the greater Richmond metro area and one serves the Petersburg area for coverage that includes the counties of Chesterfield, Dinwiddie, Goochland, Hanover, Henrico, New Kent, Powhatan, and Sussex.
- Southwest
 - Mountain Empire PACE in Big Stone Gap serves the counties of Lee, Norton, Scott, and Wise.
 - AllCare for Seniors PACE in Cedar Bluff serves the counties of Buchanan, Dickerson, Russell, and Tazewell.
- Roanoke Valley
 - Kissito PACE in the city of Roanoke serves the Roanoke Valley as well as Blacksburg and surrounding counties.
 - Centra Health PACE in Lynchburg serves the city the counties of Amherst, Appomatox, Bedford, Campbell, and Nelson.
 - Blue Ridge PACE in Charlottesville serves the city and surrounding counties.
- Southside
 - Centra PACE in Farmville serves the city and surrounding counties.

➤ Northern Virginia

- InovaCares for Seniors in Fairfax County serves that area.

Each PACE location provides the full scope of services under the Medicaid State Plan (described in the **Medicaid** chapter of this *Assessment*). Each PACE participant receives comprehensive assessment and treatment planning from an Interdisciplinary Team (IDT) of professionals who are specialists with at least one year of paid experience working with the elderly population. The IDT directly provides or arranges for individualized, comprehensive supports and services, and additionally coordinates medical and other services needed or requested by a participating individual. PACE service delivery is guided by state and federal regulations.

Locations for PACE services are determined by the state **Department for Medical Assistance Services (DMAS)**, based on analysis of Medicaid enrollee data and on exploration of interest by local or regional service providers resulting from outreach efforts. Typically, PACE locations are planned where higher concentrations of enrollees (who are 55 or older and qualify for both Medicaid and Medicare) reside. PACE operations began with 1 program location in SFY 2007. DMAS expanded PACE to 6 programs in SFY 2010, and, in SFY 2013, PACE had 14 program locations. As PACE coverage has expanded, so have the number of individuals served by the program. **Table 72** lists the number served through PACE in SFY 2007, the initial year of operation, as well as participation in the past four SFYs.

Table 72. Number Receiving PACE Services by SFY					
State Fiscal Year	2007	2010	2011	2012	2013
Number served	123	626	810	901	1,090

Source: Department of Medical Assistance Services.

At the time of this assessment, DMAS was considering PACE expansion requests from several areas of the State. Implementation of new PACE operations is expected after July 1, 2014 (in SFY 2015).

Each PACE program submits an annual report directly to DMAS that includes (in aggregate) demographic and related information on the individuals served. One sub-population identified in the annual report is the number of its participants who are elderly and who have a documented diagnosis of **intellectual disability (ID)**. At the end of SFY 2013 (June 30), only 3 percent (or 33 individuals) of total PACE participants statewide were elderly individuals who had an ID diagnosis. These individuals were served primarily by PACE operations in the Richmond metropolitan area and in the Tidewater area. This percentage is dramatically different from percentages reported by DMAS for June 21, 2010 (36.3 percent or 185 individuals) for the *2011 Assessment of the Disability Services System*, which may have been inaccurate.

c. Cost and Payment for PACE Services

PACE is a federal program available to states through the **US Department of Health and Human Services**. PACE is a dual-capitated, single-payment benefit program that is funded through the Medicaid and, as applicable, Medicare health insurance programs. DMAS annually identifies the *average cost* of services per PACE participant in order to demonstrate the cost effectiveness of PACE over alternative institutional settings. DMAS data indicate that the annual average cost per PACE participant was \$25,620 during SFY 2010, and was \$31,219 per participant in SFY 2013.

Total **expenditures** for PACE have increased as the number of programs and individuals served has expanded. Cost variation occurs based on the evolving service needs of those served in each program and in each region. Total PACE expenditures for the past four SFYs are provided in **Table 73**.

Table 73. PACE Expenditures by SFY			
SFY 2010	SFY 2011	SFY 2012	SFY 2013
\$16,038,014	23,388,039	\$28,906,686	\$34,029,185

Source: Department of Medical Assistance Services

d. Monitoring and Evaluation of PACE Services

Federal PACE regulations and state regulation (12 VAC 30-120-62) assign responsibility for oversight of the Program of All-inclusive Care for the Elderly (PACE) to the **Virginia Department of Medical Assistance Services (DMAS)**. Under regulation 12 VAC 30-120-1060, DMAS has the specific responsibility for determining whether to extend PACE coverage to another area of the State, the schedule for doing so, and implementation of a competitive Request for Application (RFA) process. 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 in compliance with federal guidelines; 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 et seq.), and comply with DMAS regulations, policies, and procedures. Prior to initiation of a PACE location, DMAS conducts an onsite **State Readiness Review** and provides training on services and referral processes to all pre-admission screeners in localities covered by the new PACE. CMS staff, or its contracted staff, in collaboration with DMAS, also conducts an onsite review and evaluation of each new PACE.

DMAS conducts quarterly **Quality Management Reviews** of each PACE in operation to ensure that the health, safety, and welfare of all participants are protected and that each program’s services are in compliance with both federal and state regulations. All reviews

include a thorough examination of all PACE processes and procedures, care plans, and participants' medical records. DMAS also conducts participant and family satisfaction surveys for each PACE to gather their perceptions about enrollment procedures, information sharing, quality of services, and other program features. If a review finds a provider's non-compliance to be significant enough to warrant such action, DMAS can retract Medicaid payments, terminate the provider agreement, or do both.

As with its Medicaid program, DMAS is accountable to the federal Centers for Medicare and Medicaid Services (CMS) for compliance with PACE service and programmatic requirements as well as expenditures. (Details about reporting of Medicaid expenditures and CMS oversight are provided in the **Medicaid** chapter of this *Assessment*.)

N. 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.

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ATLFA Fund

<http://www.atlfa.org/>

Brain Injury Association of Virginia (BIAV)

<http://www.biav.net>

Disability Law Center of Virginia (formerly Virginia Office for Protection and Advocacy, VOPA)

<http://disabilitylawva.org/>

SeniorNavigator

<http://www.seniornavigator.org>

Statewide Independent Living Council (SILC)

<http://www.vasilc.org/statewideindependentlivingcouncil.htm>

US Administration on Aging (AOA)

<http://www.aoa.gov>

Community Living Program

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

Virginia Association of Area Agencies on Aging (VAAAA)

<http://vaaaa.org>

Virginia Association of Centers for Independent Living (VACIL)

<http://vacil.org/>

Virginia Association of Community Services Boards

<http://www.vacsb.org>

Weldon Cooper Center, University of Virginia

<http://www.coopercenter.org/demographics/publications/>

2. State Websites Referenced

Auditor of Public Accounts (APA)

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

Division of State Internal Audit

http://www.doa.virginia.gov/DSIA/Annual_Survey.cfm

Comprehensive Services Act (CSA) for At-Risk Youth and Families

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

Child and Adolescent Needs and Strengths (CANS) Assessment

<http://www.csa.virginia.gov/html/cans/cans.cfm>

CSA Statewide Statistics and Reports

<http://www.csa.virginia.gov/publicstats/index.cfm>

Reports and Publications

http://www.csa.virginia.gov/html/manual_pubs/csa_reports_publications.cfm

State Executive Council

http://www.csa.virginia.gov/html/sec_slat/sec.cfm

Systems of Care

http://www.csa.virginia.gov/html/systems_of_care/systems_of_care.cfm

Wraparound Center of Excellence

<http://www.csa.virginia.gov/COE/coe.cfm>

Department for Aging and Rehabilitative Services (DARS)

<http://www.vadars.org>

Division for the Aging

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

Area Agencies on Aging

<http://www.vda.virginia.gov/aaalist.asp>

No Wrong Door Initiative

<http://www.vda.virginia.gov/nowrongdoor.asp>

Public Guardianship and Conservatorship Program

<http://www.vda.virginia.gov/vapublicguardpgm.asp>

Community Based Services Division

<http://vadars.org/community.htm>

Brain Injury Services Coordination (BISC)

<http://vadars.org/cbs/biscis.htm>

Centers for Independent Living (CILs)

<http://vadars.org/cbs/cils.htm>

Community Rehabilitation Case Management (CRCM)

<http://vadars.org/cbs/ltrcm.htm>

Personal Assistance Services (PAS)

<http://vadars.org/cbs/pas.htm>

Virginia Assistive Technology System (VATS)

<http://www.vats.org>

Virginia Reuse Network

<http://www.vats.org/atrecycling.htm>

Virginia Brain Injury Council

<http://www.DARS.virginia.gov/vbic.asp>

Woodrow Wilson Rehabilitation Center

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

Assistive Technology

<http://www.wwrc.virginia.gov/AssistiveTechnology.htm>

Brain Injury Services

<http://www.wvrc.virginia.gov/BrainInjury.htm>

Spinal Cord Injury Program

<http://www.wvrc.virginia.gov/SpinalCordInjury.htm>

Department for the Blind and Vision Impaired (DBVI)

<http://www.vdbvi.org>

Rehabilitation Teaching/Independent Living

http://www.vdbvi.org/independent_living.htm

Older Blind Grant Program Annual Reports

<http://www.afb.org/info/programs-and-services/professional-development/experts-guide/older-blind-grant-program/1235>

Department for the Deaf and Hard-of-Hearing (VDDHH)

<http://www.VDDHH.org>

Interpreter Services

<http://www.VDDHH.org/IpAbout.htm>

Outreach Services

<http://www.VDDHH.org/OrAbout.htm>

Technology Services

<http://www.VDDHH.org/TechIntro.htm>

Technology Assistance Program

<http://www.VDDHH.org/tapabout.htm>

Virginia Relay

<http://www.varelay.org>

Virginia Quality Assurance Screening

<http://www.VDDHH.org/IpVqas.htm>

Department of Behavioral Health and Developmental Services (DBHDS)

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

Core Services Taxonomy 7.2

<http://www.dbhds.virginia.gov/documents/reports/OCC-2010-CoreServicesTaxonomy7-2v2.pdf>

Office of Community Contracting

<http://www.dbhds.virginia.gov/OCC-default.htm>

Office of Developmental Services

<http://www.dbhds.virginia.gov/ODS-default.htm>

Individual and Family Support Fund

<http://www.dbhds.virginia.gov/ODS-IFSP.htm>

Person-Centered Practices

<http://www.dbhds.virginia.gov/ODS-PersonCenteredPractices.htm>

Reports and Survey Results

<http://www.dbhds.virginia.gov/occ-default.htm>

Waivers

<http://www.dbhds.virginia.gov/ODS-MRWaiver.htm>

Waiver Wait Lists

<http://www.dbhds.virginia.gov/ODS-UsefulInformation.htm#waitlists.htm>

Office of Human Rights

<http://www.dbhds.virginia.gov/OHR-default.htm>

Office of Licensing

<http://www.dbhds.virginia.gov/OL-default.htm>

Office of Planning and Development

<http://www.dbhds.virginia.gov/OPD-default.htm>

Omnibus Budget and Reconciliation Act (OBRA)

<http://www.dbhds.virginia.gov/omh-OBRA.htm>

Settlement Agreement with US Department of Justice

<http://www.dbhds.virginia.gov/Settlement.htm>

START program

<http://www.dbhds.virginia.gov/settlement/121022START.pdf>

State Board for Behavioral Health and Developmental Services

<http://www.dbhds.virginia.gov/adm-StateBoardDefault.htm>

Department of Health (VDH)

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

Division of Long Term Care

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

Office of Family Health Services

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

Office of Licensure and Certification

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

Department of Health Professions

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

Department of Medical Assistance (DMAS)

<http://dmasva.dmas.virginia.gov/default.aspx>

Behavioral Health Services

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

Commonwealth Coordinated Care initiative

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

Children's Mental Health Demonstration Waiver

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

Long-Term Care

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

Information for Medicaid Clients

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

Department of Planning and Budget (DPB)

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

General Assembly of Virginia

<http://viriniageneralassembly.gov/>

Code of Virginia

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

House Appropriations Committee

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

Joint Commission on Health Care

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

Senate Finance Committee

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

State Budget Information

<http://viriniageneralassembly.gov/virginiaStateBudget.php?secid=22&activesec=4#!hb=1&mainContentTabs=0>

Joint Legislative Audit and Review Commission (JLARC)

<http://jlarc.virginia.gov/reports.shtml>

Office of the Attorney General of Virginia

<http://www.oag.state.va.us/>

Official Opinions

<http://www.oag.state.va.us/Opinions%20and%20Legal%20Resources/Opinions/index.html>

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

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

Office of the State Inspector General (SOIG)

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

IG for Behavioral Health and Developmental Services

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

Semi-Annual Reports

<http://www.oig.virginia.gov/rpt-AnnualSemiAnnual.htm>

Special Studies

<http://www.oig.virginia.gov/rpt-specialstudies.htm>

Virginia Administrative Code

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

Virginia Easy Access

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

Virginia Performs

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

Health and Human Resources Secretariat

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

State Agency Strategic Plans

<http://www.vaperforms.virginia.gov/agencylevel/index.cfm>

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