

VI. Health Care

A. What Are Health Services?

The health services system for Virginians, with or without disabilities, is diverse and complex, involving sources of information, resources, and direct services at all levels of government and from nonprofit and for-profit organizations and practitioners. Describing all aspects of that system is beyond the scope of this report. The contents of this chapter will briefly detail the availability, provision, and financing of general and specialized preventative and recuperative care from public sources. Persons with disabilities may or may not be a recognized or readily identifiable recipient of these services which are more broadly targeted than some of the programs and services discussed in other chapters of this report. The chapter will also include certain programs directed at the general population that screen for disabilities and subsequently provide resources or referrals for related disability services. The services included in this chapter are generally not specific to whether an individual resides in an institution or in the community. Services specifically linked to institutional or community living supports are described in those chapters of the report.

While in concept the Virginians with Disabilities Act and the federal Americans with Disabilities Act ensure that access to health services for people with disabilities should be no different than for people without disabilities, in practice this is not always the case. In his 2005 *Call To Action To Improve the Health and Wellness of Persons with Disabilities*, the U.S. Surgeon General reported that significant financial, physical, educational, and attitudinal barriers still exist, and those barriers limit the availability and accessibility of health and wellness information and services for people with disabilities. As a result, significantly fewer persons with disabilities (28.4 percent) report their health to be excellent or good than the general population (61.4 percent), and people with disabilities are at greater risk for secondary conditions both related to their disabilities and independent of them.

For example, both physical and cognitive limitations can restrict their ability to exercise, eat healthy, and maintain an appropriate weight. Lifestyles are often sedentary due to mobility restrictions, and, like many others without disabilities, persons with disabilities may lack an appreciation of the need and ways to exercise, or they may find that fitness equipment and programs that have been adapted to their needs are inaccessible. Similarly, adapted examination and screening equipment is often unavailable or practitioners are poorly trained in its use. Wheelchair users and those dependent on therapeutic equipment may find it nearly impossible simply to determine and track their weight. Collectively, these factors and others contribute to greater risk for diabetes, heart and kidney disease, stroke, arthritis, certain types of cancer and infections, and many other health problems related to lack of exercise, poor diet, obesity, and limited access to health and wellness services.

In Virginia, these conclusions are supported by analysis of 2000–2002 data from the federal Centers for Disease Control Behavioral Risk Factor Surveillance System (BRFSS) completed by Virginia Commonwealth University's Survey and Evaluation Research Laboratory (SERL) for the Virginia Department of Health's (VDH) Health Promotion for People with

Disabilities project. In its 2004 report, SERL found that Virginians with disabilities tend to be older, less well educated, and poorer than the general population. In addition, although their levels of insurance coverage were similar to the general population and they were actually more likely to be aware of sources of care and to have had some types of health screenings, people with disabilities were twice as likely to have been unable to find needed health care in the past year. They were also three times more likely to have unmet health-care needs and more likely to have poor health habits. As might be expected, their risk and incidence of chronic health problems were also significantly greater. Further discussion of these and other areas of concern involving health services for people with disabilities, as well as recommendations for addressing them, may be found later in this chapter. Detailed statistical information may be found in the SERL report and the VDH Division of Chronic Disease Prevention and Control's 2006 *Chronic Disease in Virginia: A Comprehensive Data Report* which are included in the references at the end of the chapter.

B. Who Is Eligible for Health Services?

Eligibility for publicly funded or operated health services varies. For most programs, the eligibility criteria apply equally to people with and without disabilities. These criteria typically relate to the individual's age, family income, and insurance coverage, as well as whether an individual belongs to a group at special risk for a certain health problem now or in the future. In addition, services are not consistent across the state. The type and scope of services available in each region of the Commonwealth varies based on local needs and funding as well as on differing risk levels for certain health problems. Restrictions based on financial need are detailed in Section V, Cost and Payment Sources for Services of this report. Other eligibility criteria are detailed, wherever appropriate and available, for each individual program listed below.

In this section, basic descriptions for each program covered in this chapter accompany their eligibility information. Where appropriate, more-detailed information on access to programs, their services, and their funding sources is featured in later sections of this chapter. A list of resources for additional information, including relevant Web sites, concludes this chapter.

Virginia Department of Health (VDH): The vast majority of the Health Department's services listed below are authorized under Title 32.1 of the *Code of Virginia*. Other relevant state and federal statutory information is also listed as appropriate or may be found at the VDH Web site.

As noted above, in 2002, with the support of the federal Centers for Disease Control (CDC), VDH initiated a project entitled **Health Promotions for People with Disabilities (HPPD)**. The HPPD task force developed a state plan to address needed improvements to both the availability and the delivery of health and wellness programs for people with disabilities. Taskforce membership includes statewide representatives from VDH, local health districts, various state disability services agencies including the Virginia Board for People with Disabilities, and a wide range of private organizations. Data collection, outreach, accessibility, and awareness initiatives by this project continue to grow as a result of direct VDH support, of grants from CDC and other sources, and through partnerships among the participating

organizations. VDH staff members involved with the HPPD initiative have been instrumental in compiling the following information.

The **Virginia Arthritis Project (VAP)**, an initiative of the Division of Chronic Disease Prevention within the VDH Office of Family Health Services, works in partnership with governmental and nongovernmental agencies, including the Local Health Districts, the Arthritis Foundation, and the federal CDC, to increase awareness of this disabling disease, prevent arthritis whenever possible, promote early diagnosis and treatment, collect data on its impact, and improve the quality of life of persons with arthritis. Citing the 2004 Virginia Behavioral Risk Factor Surveillance System report, the Virginia Arthritis Fact Sheet on the project's Web site, indicates that approximately 1.64 million Virginia adults have arthritis, with 37 percent of those adults experiencing related limits to their daily activities. The VDH Strategic Plan indicates that 71,521 of these individuals currently receive arthritis-related services. These services include distribution of information to target populations and practitioners on the causes, prevention, and care of arthritis and referrals for related medical care. Information or referrals from the VAP are available to anyone, with or without disabilities, regardless of income.

A collaboration between the Division of Women's and Infants' Health and the Division of Child and Adolescent Health in the Office of Family Health Services, **Bright Futures Virginia** provides training and related materials to families and to public and private health professionals. The Bright Futures program helps these families and health professionals assess the physical and mental health needs of children from birth through adolescence, determine if their progress is developmentally appropriate, and promote healthy growth and a smooth transition from pediatric to adult health services. Bright Futures also encourages family and community involvement in local health-care planning, parental advocacy on behalf of children's needs, and personal responsibility by teens regarding their health care. The nationally established *Bright Futures Guidelines* are the standards for child and adolescent health care adopted by Virginia. These guidelines call attention to the special developmental needs of children with disabilities and include sections focusing on individual disabilities. While Bright Futures does not specifically target the families of children with disabilities or provide direct care services, its activities lead to earlier identification of disabilities by increasing general awareness of what is developmentally appropriate. This leads to quicker referrals to indicated services and supports, making it a key contributor to Virginia's disability services system.

The **Children With Special Health Care Needs (CSHCN)** program, located in the Division of Child and Adolescent Health of the VDH Office of Family Health Services, administers multiple service networks that work with families, service providers, and local communities to identify children with serious, persistent health-care needs and to promote their optimal health and development. CSHCN programs assess individual and community needs and available resources, develop appropriate policies and practices to address them, and subsequently provide and support a variety of services for individuals and by community or disability specific need.

In its Strategic Plan and on the Virginia Performs Web site, VDH reports that, during fiscal year 2007, 6,808 of the more than 190,600 children whom it has identified as potentially

needing CSHCN care-coordination services are currently receiving them. Specific information on each of the CSHCN service networks follows, accompanied by data on numbers served where available.

Care Connection for Children provides services for children with medical disorders having a physical basis, including physical disabilities, that have lasted, or are expected to last, at least one year and (1) require services above and beyond what is typical for a child's age or require special ongoing supports at home or school; (2) limit a child's abilities or activities in comparison with his or her peers; or (3) make the child dependent on compensatory medical or assistive services and supports. All children from birth to age 21 and their families are eligible for services. Care coordination, medical insurance benefits' evaluation and coordination, and referral to other resources are provided at no charge. A limited pool of funds, managed by Care Connection, is available to assist low income and uninsured families with payments for other required services. Care Connection also performs community outreach and provides training and consultation to a wide variety of community service providers that result in reciprocal referrals based on the needs of the individual child and family. The VDH Strategic Plan reports that, in fiscal year 2005, the Care Connection network of Centers for Excellence for Children with Special Health Care Needs provided services to 4,160 children.

A parallel program to Care Connection, the **Child Development Services (CDS)** program facilitates the availability and accessibility of services for children and adolescents suspected of or diagnosed as having a developmental, learning, or behavioral disorder. All children from birth to age 21 are eligible for services, and there is a sliding-fee scale based on income for fee-based services. CDS is also actively involved in community outreach and training that results in referrals to and from the program to other parts of the health and disability services system. VDH reports on the Virginia Performs Web site that CDS Clinics served 1,535 children during fiscal year 2007. (Data in the 2006 edition of this publication and elsewhere inadvertently reported number of clinic visits rather than the unduplicated count of patients.)

Unlike other parts of the CSHCN network, services provided under the **Bleeding Disorders Program** are available to persons of all ages. Outreach, direct services, and referrals are aimed at the general population, and specifically to health-care professionals, to facilitate identification of and care for Virginians with inherited bleeding disorders. Services are available, regardless of income, through a statewide network of comprehensive care centers. The VDH Strategic Plan reports that these centers provided services to 243 children and adults in fiscal year 2005.

Two key components of the CSHCN network's **Pediatric Screening and Genetic Services** unit, the **Virginia Early Hearing Detection and Intervention (VEHDI)** program and the **Virginia Genetics Program**, are responsible for ensuring that newborn Virginians are screened for potentially disabling conditions and are then directed to appropriate resources for follow-up. Each of these programs is aggressive in its outreach to the general population and especially to health-care professionals and organizations.

According to the VDH Web site, in 2006, 99.3 percent of 108,716 newborns were screened for hearing problems in Virginia within one month of birth, and 2.9 percent of those screened did not pass. Of those, 83.5 percent received follow-up assessments. An additional 1.7 percent who passed the screening were identified as potentially needing services at a later time. The VDH Strategic Plan reports that 69.9 percent of children needing follow-up services in fiscal year 2005 received it within three months; however, it also notes that the actual number may be higher due to difficulties in obtaining follow-up reports from service-providers.

In its Strategic Plan and on the Virginia Performs Web site, VDH reports that 99.7 percent of Virginia newborns are screened for metabolic disorders and that 100 percent of those needing follow-up are referred for services. Historical data from the **Virginia Congenital Anomalies Reporting and Education System (VaCARES)**, the surveillance system for Virginia Genetics Program, indicate that on average 5 percent of Virginia newborns are identified as having congenital anomalies targeted by Virginia's screening programs. Of the newborns so identified, 2 percent have significant needs requiring referral for follow-up services

Complimenting the CSHCN programs described above, the **Virginia Sickle Cell Awareness Program** within the Department of Health's Division of Women's and Infants' Health in the Office of Family Health Services coordinates services related to the detection and treatment of sickle cell disease. All Virginians under age 21 are eligible for services that are provided through four regional Pediatric Comprehensive Sickle Cell Clinics located at major medical centers as well as through Community-Based Sickle Cell Programs. There are no financial eligibility requirements to receive services, but fees are charged by each clinic using an income-based sliding scale. In an October 2007 presentation to the Joint Commission on Health Care, VDH estimated that 3,700 Virginians have sickle cell disease or other hemoglobinopathies and that these numbers will increase significantly as better detection and treatment extends their life expectancies. Since screening began in 1989, Virginia has identified 1,257 newborns with the disease, a number that grows by approximately 75 each year.

The Virginia Department of Health's **School Health Program** within the Division of Child and Adolescent Health of the Office of Family Health Services acts primarily as a training, technical, and evaluative resource for the Virginia Department of Education (DOE). Having direct responsibility for the provision of school health services, program staff members are involved with developing and promoting standards, procedures, and educational materials provided by local school districts that affect direct services for children with disabilities. All Virginia schoolchildren with disabilities are guaranteed appropriate services (including health services required to obtain educational benefit) under the federal Individuals with Disabilities Education Improvement Act (IDEIA). The requirements of IDEIA and how they are met can be found in the Education chapter of this report.

The **Breast and Cervical Cancer Early Detection Program (BCCEDP)**, also known as "Every Woman's Life," is located in the Division of Women's and Infants' Health of the Office of Family Health Services and authorized by the federal Breast and Cervical Cancer Mortality Prevention Act of 1990. BCCEDP provides referrals to local service providers and appropriate follow-up care for women, with or without disabilities, who meet certain age, income, and lack

of insurance coverage requirements. While not a disability-specific initiative, outreach to special populations who experience barriers to screening and follow-up care, including women with disabilities, is an objective of BCCEDP. Statewide data on its activities specifically involving women with disabilities is not collected.

Part of a complex of programs within the Division of Women's and Infants' Health of the Office of Family Health Services, **Baby Care** services are offered by approximately twenty local health districts across the state. Only pregnant women and infants under age two who are eligible for Medicaid (FAMIS Plus) or FAMIS and who are not already enrolled in a Medicaid-managed care organization are eligible. Screenings and assessments provided through Baby Care, and by Medicaid-managed care organizations for their enrollees, identify and further target services to families who are likely to experience medical, social, psychological, and environmental risks leading to poor birth outcomes or problematic child development. As a result, both mothers and infants with disabilities are among those most likely to be served.

Resource Mothers, also located in the Division of Women's and Infants' Health, is a companion program to Baby Care. This program targets pregnant and parenting teens and their families from the time of pregnancy through the baby's first year and provides guidance, assistance, and referral to additional resources. Specific data on services to teens with disabilities is not kept, but the program addresses accommodations for physical and mental disabilities.

In addition, the **Virginia's Healthy Start Initiative**, also known as "Loving Steps," combines resources from these and other Virginia Department of Health programs to target four localities in Virginia where pregnant women, new mothers, and newborns are deemed to be "at risk." Three local programs—Norfolk, Petersburg, and Westmoreland County—are supported by federal funding through VDH. The City of Richmond receives direct federal funding for a fourth program. Beyond its limited geographic range, eligibility requirements and activities for this initiative are the same as for its component programs.

Although not specifically targeted to persons with disabilities and their families, services provided by the **Virginia Family Planning Program** of the VDH Division of Women's and Infants' Health in the Office of Family Services are available statewide through local health departments and are a key point of referral to other resources. Services are available to all with income-based payments using a sliding-fee scale relative to the federal poverty level.

A separate division within the Office of Family Health Services, the **Women, Infants and Children Program (WIC)** is authorized and funded through the federal Department of Agriculture. WIC's primary purpose is to provide breast-feeding and nutritional information and support to low-income mothers during pregnancy and until their children reach age five; WIC also serves, however, as an important point of referrals to other health-care services and to elements of the disability services system, where appropriate. WIC offices at local health departments screen potential participants for eligibility.

Located within the Division for Injury and Violence Prevention of the Office of Family Health Services, the **Youth Suicide Prevention** program produces and distributes educational materials and conducts training programs for families, educators, and local service providers to raise public awareness and reduce the incidence of youth suicide. Information contained in their publications and training programs include important referral data to Virginia's service system for people with disabilities, especially regarding assistance with short- and long-term mental health-care needs.

Although not specifically targeted at children with disabilities, the **Virginia Vaccines for Children** program, located in the VDH Division of Immunization of the Office of Epidemiology, partners local practitioners with providers of childhood vaccines to increase levels of childhood immunization among at-risk groups such as the uninsured, underinsured, or Medicaid-enrolled children or those from certain minority groups.

As indicated earlier, Centers for Disease Control (CDC) Behavioral Risk Factor Surveillance Survey (BRFSS) data indicate that Virginians with disabilities are three times more likely to have unmet health-care needs than the state's general population. Their levels of immunization, however, are at least as high as those for the general population for certain vaccines. This may be attributable, at least in part, to the outreach efforts of this VDH program and to the proportionately higher numbers of children with disabilities who meet its eligibility requirements.

VDH Health Care Services within the Office of Epidemiology's Division of Disease Prevention administers funds provided by the federal Health Resources and Services Administration, authorized under the **Ryan White Comprehensive AIDS Resource Emergency (CARE) Act**, to provide services and referrals for individuals with low incomes or disabilities who are not on Medicaid, have no other insurance or resources, and meet certain income limits. In addition, persons with cognitive and learning disabilities who are at greater risk for contracting and spreading HIV/AIDS have been identified as a population of special interest for outreach by the Division of Disease Prevention. Women and children with HIV/AIDS are a priority for available resources. For many individuals, with and without disabilities, the Ryan White CARE Act is the last resort for funding to support health care and other needs. In fiscal year 2006, 3,060 individuals received direct care and support services through this program, and 3,332 individuals received medications.

Area Health Education Centers (AHEC): Virginia Commonwealth University coordinates a network of eight Area Health Education Centers that provide resources and services to Virginia communities. Each AHEC is a partnership of statewide and local educational resources, professional networks, public and private health-care service providers, and the Virginia Department of Health's system of Local Health Districts and municipal health departments. As a result, each AHEC is involved in a range of projects unique to its community.

For the most part, AHEC services are not directed at the general population, but they can have an important impact on local availability and quality of health care. AHEC activities primarily target areas with shortages of health-care providers and places where there are greater

numbers of Virginians at risk for poor health habits and chronic health conditions, including people with disabilities. Although they vary from AHEC to AHEC, projects are generally undertaken that increase the number of health-care providers in appropriate areas that address educational, physical, and attitudinal barriers restricting access to health and wellness services, and that attempt to identify underserved members of communities and direct them to appropriate services. Expansion and improvement of health-care services for people with disabilities are frequently goals and outcomes of AHEC activities.

Virginia Department for the Deaf and Hard of Hearing (DDHH): In addition to its specific activities addressing the assistive technology and communications needs of individuals who are deaf or hard of hearing, which are addressed in other chapters of this report, the Virginia DDHH conducts **Outreach** activities directed at the general population. Sixteen regional outreach providers coordinate distribution of educational materials, participation in community resource fairs, and training programs. Targets of training programs include the general public, civic organizations, support groups, businesses, caregivers, public officials, and health services professionals. Additional information can be found in the Community Living Supports chapter of this report.

Virginia Department for the Blind and Vision Impaired (DBVI): The DBVI **Library and Resource Center** in Richmond and its eight affiliated regional public libraries maintain and distribute audio, large-print, and Braille information on a wide variety of subjects including health-care topics. They also provide listings of community resources including health and wellness service providers. These resources and the equipment to access them are available free of charge to eligible persons with visual, physical, or learning disabilities, and as reported on the DBVI Web site, serve an estimated 10,000 patrons with print disabilities statewide. In addition to the resource and referral materials provided by Library Services, the six DBVI **Regional Offices** are also a source for information on a wide range of community resources including those addressing health and wellness needs. The DBVI network of local **Low Vision Services** providers in communities across Virginia conduct vision assessments, follow-up counseling, and training programs. In addition to receiving referrals from DBVI, these practitioners refer individuals with vision impairments to additional services including health-care providers and sources of related disability services.

Department for the Aging (VDA): The Virginia Department for the Aging is authorized to provide oversight for all state programs funded by the federal Older Americans Act. In turn, the VDA contracts with twenty-five locally administered **Area Agencies on Aging** to provide direct services to older Virginians. Since the rate of disability increases significantly with age, the Area Agencies on Aging serve as significant resources for information of all kinds, but particularly regarding health and wellness for people with disabilities regardless of age.

Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS): Title 37.2 of the *Code of Virginia* charges DMHMRSAS with administrative and oversight responsibility for the state's publicly funded services to persons with mental illness, intellectual disabilities (mental retardation or MR), or substance use disorders. Within

the DMHMRSAS system, state Code designates local, independent **Community Services Boards** and **Behavioral Health Authorities** (collectively referred to simply as CSBs) to serve as the single point of entry for those services. CSB staff members are the primary publicly funded source of information, referrals, and mental health, mental retardation, and substance abuse services. The opportunity and ability to serve as general health and wellness information resources varies considerably between CSBs, depending on their structure and available resources. More-detailed information about the publicly funded disability services and supports available through the DMHMRSAS system of care can be found in the Community Living and Institutional Supports chapters of this report.

Virginia Birth Injury Program: The Virginia Birth-Related Neurological Injury Compensation Act was passed by the General Assembly in 1987 in response to malpractice insurance availability problems for providers of obstetric services. The Birth Injury Program, created under the Act, pays for medical and certain other expenses of children who have severe neurological injuries resulting from the birthing process. The program is intended as an alternative to traditional civil tort system malpractice litigation for obtaining compensation for injuries.

The Workers' Compensation Commission (WCC) conducts hearings and determines eligibility for claimants who seek entry into the program. To be eligible for the Birth Injury Program, an infant must meet the specific definition in the *Code of Virginia* (§ 38.2-5001) for a birth-related neurological injury, and the obstetrical services must have been performed by a physician or at a hospital that specifically participates in the birth injury program. The program was designed as a "no-fault" system of compensation, and therefore, decisions regarding acceptance into the program are not based on a finding of malpractice. When a family delivers a baby in a participating hospital or through a participating physician, the family automatically waives the right to bring a medical malpractice lawsuit against the participating physician or hospital if the baby incurs a birth injury that meets the definition in the *Code*. As of December 1, 2006, 119 infants had been accepted into the program, and as of the end of that month, 45 additional claimants had yet to be accepted into the program. The program's 2007 annual report further states that the average age for admittance into the program has been 4.2 years, with 34 of the 119 current enrollees having been admitted after the age of 5.

C. How Are Health Services Accessed and Delivered?

Most direct health and wellness services are obtained from private nonprofit and for-profit organizations and practitioners, which, as has already been stated, are too diverse and numerous to cover in the framework of this report. With a few exceptions, the public programs covered in this chapter function primarily to provide information on and referrals to these providers, support citizens in getting access to these providers, or coordinate delivery of services between them. Access points for publicly provided health-care assessment, management, and support services targeted specifically at people with disabilities are described in this chapter.

Virginia Department of Health (VDH): Community-based sources of information and services are by far the most important element in Virginia's public health service system for all

Virginians with or without disabilities. A network of thirty-five **Local Health Districts** support 119 individual municipal health departments, each with a unique combination of public and private resources, local health needs, and service array. Unless otherwise indicated, the individual VDH health initiatives listed in this chapter operate through this network either by directly providing services or by supporting local service providers. This network also collects data on health-care needs and service levels, which is reported to the VDH. Wherever specific access information on a VDH service to people with disabilities is available, this information is included under the appropriate initiative.

Information, training, and referrals from the **Virginia Arthritis Project (VAP)** are most often obtained through its Web site, local health departments, community resource fairs, and outreach to senior citizens and other organizations or to individual health-care providers. The project also supports four regional Community Arthritis Projects in partnership with the Virginia Beach, Lenowisco, Three Rivers, and Fairfax County Health Districts.

Publications and training provided by **Bright Futures** are available through the Virginia Department of Health (VDH) central office and Web site and, to varying degrees, through local health departments and their community partners. A key component of this training is “Child and Adolescent Health: Bright Futures and Early and Periodic Screening, Diagnosis and Treatment (EPSDT)” for health-care professionals. This six-module course, cosponsored by the Virginia Commonwealth University School of Medicine is available through the program’s Web site.

Care Connection for Children coordinators, educational consultants, and insurance benefit specialists work from six regional Centers of Excellence for Children with Special Health Care Needs. A complete listing with contact information may be found at the VDH Web site or by contacting the VDH’s Children With Special Health Care Needs (CSHCN) program or local health departments.

Together with Care Connection, **Child Development Services (CDS)** serves as a significant “gateway” and contributor to the disability services system. Referrals to the ten regional Child Development Clinics and regular or as-needed satellite or field clinics are made by families, schools, physicians, local health departments, social services offices, and other community and professional agencies. Clinic contact information may be obtained from the VDH Web site or by contacting the VDH’s CSHCN program or local health departments.

Virginia Bleeding Disorders Program referrals and service delivery focus on four regional bleeding disorders centers. The service emphasis at these centers varies between pediatric and adult treatment. The co-incidence of bleeding disorders and other disabilities, as well as overlap in outreach and professional networks, result in reciprocal referrals between the bleeding disorders and broader disability services systems.

The goals of the VDH **Pediatric Screening and Genetics Services** network are to improve the health of children and families by preventing birth defects and developmental disabilities, by promoting optimal child development, and by promoting health and wellness

among children and adolescents with disabilities. The diverse components of this network accomplish their missions through multilayered systems of individual service providers from both the public and private sectors that are linked by particular health conditions or disabilities.

Under Virginia law, all newborns must be screened for hearing loss and specific genetic disorders. The law also requires that appropriate explanatory and follow-up information be provided to parents and service providers and that referrals be made for appropriate medical or other services. As a key partner with the Virginia Department for the Deaf and Hard of Hearing, the VDH **Early Hearing Detection and Intervention** program is a primary source of referrals for follow-up services. Similarly, the VDH **Virginia Genetics Program** works with four Regional Genetic Centers operated by Virginia's medical schools that provide links to the appropriate resources in Virginia's disability services system.

Through the VDH **Virginia Sickle Cell Awareness Program**, all Virginia newborns are screened at birth for sickle cell disease, with results typically provided to the parents by their pediatrician. Local health departments also offer screening opportunities. These and other referral sources direct families to Pediatric Comprehensive Sickle Cell Clinics located in four major regional medical centers for follow-up counseling, care coordination, and treatment. Additional community and professional educational and support services are offered through Community-Based Sickle Cell Programs.

A network of 23 **Breast and Cervical Cancer Early Detection Program (BCCEDP)** providers conduct screenings and supply follow-up referral information. Screening sites can be identified using a toll-free number and an interactive map available on the VDH Web site or through local health departments. The program also works with VDH's Health Promotions for People with Disabilities project on outreach to women with disabilities and to arrange related training for service providers.

Care coordination, group childbirth education and smoking cessation programs, parenting classes, nutritional assessments and counseling, and homemaker services available through the **Baby Care** program are provided by approximately twenty participating local health district offices and some managed care organizations. Specific services available vary by provider, and local health districts should be contacted to learn which services are available.

Available through twenty-five Local Health Districts and other community partners encompassing eighty-one Virginia counties and cities, VDH **Resource Mothers** programs team community health workers and more experienced lay mentors from their own communities, with young mothers. Teens who are pregnant or mothers are referred to the program by local health departments, health practitioners and service providers, schools, and other community resources. Peers and family members may also make referrals. Through weekly contacts with the teen and her family, the Resource Mother provides health education, models daily living skills, makes referrals to other resources including the disability services system and public insurance programs when appropriate, and guides the teen in making a successful transition to parenthood.

The **Virginia Family Planning Program** provides comprehensive services through local health departments that assist citizens in planning and spacing pregnancies. They also provide health education and counseling on preconception health, prevention of coercive sexual activity for teens, family support for pregnant teens, avoidance of sexually transmitted diseases, and other topics. Local health departments also provide physicals and gynecological exams, conduct laboratory tests, screen for cervical cancer and sexually transmitted diseases, and distribute birth control methods of choice. Subsequent referrals are provided for follow-up treatments and other services.

Once eligibility has been determined, **Women, Infants & Children Program (WIC)** participants are directed to teams of service coordinators, trainers, and peer counselors who work out of Virginia's local health departments, satellite offices, and mobile clinics for services. These teams also serve as important points of referrals to other health-care services and to resources within the disability services system where appropriate.

Educational materials and training programs from **Youth Suicide Prevention** may be requested free of charge through its Web site, from VDH's central office, or through its Local Health Districts and their community partners.

The **VDH Virginia Vaccines for Children** program conducts outreach and provides supplies of free vaccines to both public and private practitioners who make the vaccines available to eligible children, including those with disabilities. The VDH central office, local public health departments, and other community partners provide information about this program, make referrals to participating practitioners, and coordinate participation in the program.

Outreach, referrals, and funding under the **Ryan White Comprehensive AIDS Resource Emergency (CARE) Act** are coordinated by five regional collaborations referred to as "consortia" who work in cooperation with local health departments and their community partners.

Virginia Department for the Aging (VDA) and Area Agencies on Aging: Services statewide are provided by local **Area Agencies on Aging**. Services offered by these agencies vary according to local needs and resources, but certain health- and wellness-related initiatives are provided by all. These include referrals to health and wellness providers, related educational and physical activity programs, and nutrition services. Information and referral activities are generally free of charge. Eligibility criteria and costs for physical activity and nutrition services vary by program and location. Information and services are obtained by contacting the appropriate local Area Agency on Aging directly or through the VDA Web site.

The VDA is also a major sponsor of the independent, nonprofit **SeniorNavigator** online information and resource service. This free service covers a wide range of topics of interest to the elderly with or without disabilities and their caregivers. Understandably, health care and links to appropriate resources and services are a particular emphasis. For those without online

access, SeniorNavigator information and referrals can also be obtained through a toll-free telephone number or at SeniorNavigator Centers operated by some local Area Agencies on Aging.

Virginia's growing **No Wrong Door** system, an interagency collaborative project led by VDA, is a key component of Virginia's efforts to provide an integrated, online, "one-stop" resource for information on adult health and human services and access to the long-term supports system. Elements of No Wrong Door, for both consumers and service providers, are currently being piloted in communities across the state, with the goal of expanding the full system statewide. Details on the program are available on the VDA and SeniorNavigator Web sites.

DMHMRSAS Regional Community Service Centers: Since 1998, the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) has attempted to address health-care availability for persons with intellectual disabilities (mental retardation or MR) through creation and expansion of Regional Community Service Centers (RCSC). RCSCs, supported by state General Funds, are outpatient facilities located in and operated by DMHMRSAS Training Centers. Prior to the 2006 fiscal year, only the Northern Virginia Training Center operated a Regional Community Service Center. DMHMRSAS has since received funding from the General Assembly to begin RCSCs at Central Virginia and Southwestern Virginia Training Centers. The remaining two training centers, Southside Virginia and Southeastern Virginia, are funded to begin development of RCSCs in fiscal year 2008. Service priorities for each RCSC are based on regional needs of persons with intellectual disabilities (MR), and referrals for services must be made through local Community Services Boards.

Virginia Birth Injury Program: To enter the Birth Injury Program, families must file a petition with the Virginia Workers' Compensation Commission (WCC). Most families will need an attorney to represent them, although it is technically not required. The petition process includes a review of the case by a panel of expert physicians from one of three state medical schools, a review by program administrators, and an initial hearing by a WWC administrative judge within 120 days of the petition being filed. The WWC then enters a decision on eligibility and admission to the program. Either party can appeal the decision to the full Commission. Further appeals are to the Virginia Court of Appeals and the Supreme Court of Virginia.

"Medical Homes": Before concluding its discussion of access and delivery of health services, the Board would like to call attention to the emerging concept of medical homes. This concept has existed since the 1960s but has recently garnered renewed attention. A June 2006 Associated Press story, that appeared in the *Washington Post* and other publications, defined a medical home not as a physical place where medical and related care is provided. Instead, it is a single place or group of people that an individual or family can turn to for assistance in coordinating medical and related care. It is also distinctly different from the concept of "managed care," which serves more of a "gate-keeper" role. Ideally, in a medical home, the wishes and contributions of patients, and their parents if they are children, are respected, and the professionals who advise and assist them take a proactive, team approach to helping them coordinate information from multiple providers and directing them to appropriate resources in the community.

In Virginia, the Department of Mental Health, Mental Retardation and Substance Abuse Services provided seed money to help build a coalition in Central Virginia called **Medical Home Plus** to improve care coordination for children with disabilities and special health needs. A federal grant supports involvement in Medical Home Plus by thirteen pediatric practices. Working with partners at Central Virginia Care Connection for Children, Family Voices, Parent to Parent, the Title V program at the Department of Health, and the Virginia Chapter of the American Academy of Pediatrics, Medical Home Plus informs and assists parents, practitioners, and insurers in establishing medical homes that “connect the dots” to create a more seamless service delivery system, leading to a higher level of wellness and quality of life for the child and greater satisfaction for all its participants.

D. What Health Services Are Available?

The previous section contains basic information on Virginia’s principal publicly funded health-care information and service providers with specific relevance to people with disabilities. In this section, additional details are provided on some of these services, primarily those where direct services to individuals with disabilities are provided that go beyond the provision of basic information and referrals. As already indicated, additional details may be obtained through the Web sites and other references listed at the end of this chapter.

Virginia Department of Health (VDH): Families of children diagnosed with medical disorders having a physical basis, including physical disabilities, who are served by the six regional **Care Connection for Children** Centers of Excellence are directly assisted in obtaining healthcare assessments and specialty medical care, determining and obtaining insurance coverage and payments from either private or public sources, and gaining access to other relevant services and supports from the health and disability services systems. Care Connection staff members work to establish family-to-family support networks. They also search for additional potential community resources, particularly specialty medical services, and then train and consult with them to expand the availability of services and supports.

Each of the ten regional clinics managed by VDH **Child Development Services (CDS)** develops teams to assist the families of children with learning, developmental, or behavioral disabilities. These teams consist of a pediatrician, nurse, social worker, educational consultant, psychologist, and other professionals as appropriate. The teams provide diagnostic assessments and plans for future services and supports. They also coordinate delivery of those services and supports with the Department of Social Services, Community Service Boards and mental health providers, local health departments, local school divisions, early intervention services, Head Start programs, and other resources as appropriate. Again, as is the case with Care Connection, CDS staff members search for additional potential community resources, and then provide those resources with training and consultation to expand the availability of services and supports.

Individuals with inherited bleeding disorders and their families receive direct services through one of the four comprehensive regional centers supported by the **Virginia Bleeding Disorders Program**. Teams at these centers consist of specially trained physicians, nurses,

social workers, physical therapists, orthopedic surgeons, infectious disease specialists, dentists, genetic counselors, nutritionists, and educators. These teams develop and implement plans that address individual needs for services and supports. Families are also assisted in coping with emotional, social, educational, financial, and workplace concerns.

Once screening has identified a child with current or potential hearing loss, the **Virginia Early Hearing Detection and Intervention (VEHDI)** program provides parents with information on the importance of early intervention, available resources, and what to expect in the future. Parents are also directly assisted in arranging for follow-up assessments and in obtaining communications and educational support, assistive technology, and other services, including referrals to appropriate resources of the Virginia Department for the Deaf and Hard of Hearing.

VEHDI staff are responsible for ensuring that physicians and hospitals provide all prospective parents with information on screening requirements, that screenings are performed, and that notifications of the results of screenings are provided to parents, physicians, primary care providers, and the **Virginia Congenital Anomalies Reporting and Education System (VaCARES)** surveillance system. To facilitate these practices, VEHDI staff develop policies and procedures, identify best practices, recruit additional community resources, and provide training and consultation to practitioners.

Direct services provided through the **Virginia Genetics Program** are complex and vary considerably depending on the specific genetic condition. In general, Genetics Program staff members ensure that physicians and hospitals collect necessary screening samples that are then tested by the state Department of General Services' Division of Consolidated Laboratories under contract to the Virginia Department of Health. Program staff members then ensure that parents, physicians, primary care providers, and the VaCARES surveillance system are notified of the results of those screenings, and that parents are referred to the appropriate resources for follow-up.

Further testing, counseling, education, and referral to services are provided by the four Regional Genetic Centers. In situations where metabolic treatments or special foods are required, families are referred to one of three regional Metabolic Treatment Centers. Physicians and nutritionists associated with those centers help to develop a plan of care, and, when necessary, special foods are provided.

Community Service Boards (CSB): As mentioned previously, an extensive range of services can be obtained through local CSBs by persons with mental health, intellectual disabilities (mental retardation or MR), and substance use disorders. The services provided, however, vary between CSBs. In addition to mandated emergency services, a CSB may provide or contract for provision of prevention and early intervention services, case-management, acute psychiatric inpatient treatment, outpatient services, and residential and day support services. The details of these services are too extensive to discuss in the context of this chapter, but can be obtained directly from the DMHMRSAS Web site or by contacting local CSBs. Additional information

on many of these services related to institutional and community living supports for people with disabilities can be found in those chapters of this report.

Regional Community Service Centers: Also previously mentioned, these existing and planned DMHMRSAS facilities can provide medical, dental, and other specialized clinical services for individuals with intellectual disabilities (MR) that might otherwise be unavailable or inaccessible in the community. Moreover, RCSCs can provide clinical consultations to community healthcare professionals and residential providers for further support of community living opportunities and options for those individuals. In addition, in partnership with colleges and universities, RCSCs can provide training to students pursuing health-care careers, thereby potentially expanding the workforce available to provide community services.

Virginia Birth Injury Program: Services provided by the Birth Injury Program are delineated in the *Code of Virginia* (§ 38.2-5009). They include medical, hospital, rehabilitation/therapy, residential and custodial care; compensation for lost earnings from age 18 to 65; special equipment or facilities; reasonable claim filing costs including attorney's fees; and medically necessary travel. Expenditures that are not covered include those covered by other government programs, expenses covered by prepaid health plans or health maintenance organizations, and expenses covered by private insurance.

In a controversial decision made in 2000, the trust home benefit, which enabled families to obtain accessible homes or have renovations made to their own homes, was eliminated. In 2004, in order to improve the solvency of the program and reduce its long-term debt, the General Assembly passed legislation authorizing payment to attorneys representing families filing for benefits only if they won a case. This was also expected to result in fewer children entering the program since attorneys would be less likely to take a case without a guarantee of payment for their services.

E. Cost and Payment for Health Services

In general, financial resources to cover the costs of health and wellness services for people with disabilities come from the same sources as for the general population: out-of-pocket expenditures, payments by private and public insurance, or government-funded "free" services. Public funding is usually a mixture of federal, state, and local resources. State funding for services may be allocated from state General Funds or earmarked for a specific service. Some mention of funding sources has also been included in earlier sections in relationship to statutory authorizations. This section will detail only the most significant of those sources of funding. Specific data on numbers of participants and amounts of payments for individual categories of service are provided in other chapters of this report as appropriate and available.

Numerous sources, including those mentioned at the start of this chapter, have reported that people with disabilities are typically poorer and have less access to private health insurance than the general population. This makes the population with disabilities and their families more reliant on public insurance programs and other government-subsidized services.

Concerns about the ever-rising costs of public insurance programs and limits to their coverage are resulting in annual changes at the national level to Medicaid, the State Children's Health Insurance Program (SCHIP), and other acute and long-term health-care programs of critical importance to persons with disabilities. Virginia's elected officials and service agencies are limited in their ability to influence these federal legislative actions but must constantly anticipate and react to them with adjustments to the state's finances, policies, and procedures. Federal budgetary changes pending at the time of publication of this report call for significant reductions in the growth of overall spending for these programs in coming years. To achieve these reductions, adjustments and potential real cuts in the number of eligible participants, in covered benefits, and in reimbursements to providers are likely. Differing political agendas and changes in priorities may also result in increases for some programs at the expense of decreases in others.

Anticipated federal strategies for achieving these cost savings include changes to the "match rates" that determine federal versus state liability for reimbursements, modification of tax policies, and limits to reimbursements for health-related services that may be covered by other federal initiatives. The latter could include restrictions on reimbursements for Individuals with Disabilities Education Improvement Act (IDEIA) services such as occupational and speech therapies and transportation between schools and service providers, covered in the earlier chapter on Education. Under the federal Deficit Reduction Act (DRA) of 2005, some states (not Virginia) are using "benchmark" plans to replace or limit coverage of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services for children, detailed in the Early Intervention chapter. Benchmark plans provide less-comprehensive coverage than traditional Medicaid plans and decrease the availability of needed services for both children and adults with disabilities who have significant needs. The DRA also enables states to cap the number of persons who can be served under new Medicaid waivers, described in the Community Living Supports chapter, or limit their coverage only to certain areas of a state. There may also be changes to federal regulations restricting reimbursements for targeted case management that is not deemed to be "medically necessary." This would have a negative effect on recipients of Home and Community Based Waiver services, particularly those who are transitioning from institutions to community residence and for whom case management is essential.

Medicaid: The Medical Assistance Program, generally known as Medicaid, is authorized by Title XIX of the federal Social Security Act. Using a combination of federal and state funds, Medicaid serves as a publicly funded insurance program for people on public assistance and for certain medically needy persons who meet income eligibility requirements. The federal contribution to Medicaid varies from state to state and year to year. States can determine services to be covered by Medicaid beyond the federal mandate. The federal portion of payment for a service typically varies from 50 to 83 percent of its total cost. A formula is used to set the percentage of federal payment for each state, and the state is required to cover the remaining service cost, known as "Medicaid Match," currently set at 50 percent for Virginia. Administrative costs for states are matched uniformly at 50 percent. The Kaiser Family Foundation provides a user-friendly source for basic data on individuals served, costs, eligibility,

and covered services for Medicaid and the other federally established public insurance programs listed below on its State Health Facts Web site, referenced at the end of this chapter.

Virginia's Medicaid program, officially referred to as **FAMIS Plus**, is authorized by Section 32.1 of the *Code of Virginia*. The Virginia Department of Social Services (DSS) serves as the "gateway" for persons applying for benefits and determines whether applicants meet eligibility requirements for a particular service. The Virginia Department of Medical Assistance Services (DMAS) is the designated administrator of the program. Once an individual is found to be eligible, DMAS is responsible for paying the cost of covered services for that individual. As a health insurance provider, Virginia's FAMIS Plus program covers essential medical and medically related services for low-income families with children and for people with disabilities. In addition, it funds long-term care for persons who are elderly or disabled and serves as a supplement to Medicare for recipients who have low incomes. DMAS reports that just under 171,000 Virginians with disabilities were eligible for FAMIS Plus in fiscal year 2006.

Under federal regulations, payments for certain types of health-care services are mandatory under FAMIS Plus. These include: inpatient hospital services; outpatient services at hospitals, rural health clinics, and other qualified health centers; physician and nursing facility services; skilled home health services for adults; applicable durable medical equipment; laboratory and x-ray services; medical and surgical services provided by dentists; services by nurse-midwives and certified family and pediatric nurse practitioners; early and periodic screening, diagnosis, and treatment (EPSDT) services for children under age twenty-one; and related transportation costs to receive these services.

States have the option of covering an additional thirty-three categories of services under Medicaid, with varying percentages of federal matching funds. Of these, Virginia has elected to provide services in nineteen categories. A partial list of these services includes: prescription drugs; skilled nursing facility services for persons under age 21; home health services such as physical therapy, occupational therapy, and speech therapy; dental services for individuals under age 21; inpatient and outpatient physical therapy and related services; case management services; community mental retardation services; services in Intermediate Care Facilities for Persons with Mental Retardation (ICFs-MR); and home- and community-based waiver services such as personal care, adult day health-care, respite, private duty nursing, case management, mental retardation services, and services for people with developmental disabilities (DD). Details of these services and others including eligibility requirements and types of approved providers can be found in other chapters of this report, on the DMAS Web site, and in appropriate DMAS publications.

State Children's Health Insurance Program (SCHIP): In addition to Medicaid (FAMIS Plus), the Department of Social Services serves as the "gateway" while the Department of Medical Assistance Services administers two additional supplemental publicly funded general insurance programs targeted at children under the State Children's Health Insurance Program. Each of these programs has a different menu of covered services, age range for participants, and income eligibility limits. Required state matching fund rates for these programs are also generally lower

than for Medicaid. Using data supplied by the federal Centers for Medicare and Medicaid Services (CMS), the Kaiser Family Foundation's State Health Facts Web site reports that 78,745 children were enrolled in Virginia's SCHIP programs in June 2006, and that total state (35 percent) and federal (65 percent) expenditures for the program in fiscal year 2006 came to \$147,504,631.

Medicaid Expansion coverage extends to families with an income between 100 percent and 133 percent of the federal poverty level (FPL), but coverage is limited to children ages 6 through 18. **Family Access to Medical Insurance Security (FAMIS) Plan** coverage extends to families with income between 133 percent and 200 percent of the FPL and is limited to children ages 0–18 and younger. In the past, FAMIS was referred to as the Children's Medical Security Insurance Plan (CMSIP), and it is authorized separately from Medicaid under Title XXI of the Social Security Act.

In comparison, the children covered under Medicaid (FAMIS Plus) **early and periodic screening, diagnosis, and treatment (EPSDT)** services must have family income of no more than 133 percent of FPL. Coverage is limited to children ages 0–20. Services covered for children under Medicaid (FAMIS Plus), Medicaid Expansion, and FAMIS are different, and generally more extensive, than those covered under Medicaid (FAMIS Plus) for adults. Additional information on EPSDT services may be found in the Early Intervention chapter of this report.

Dental, orthodontics, and limited oral surgery services for children under Medicaid (FAMIS Plus) and FAMIS are managed by the combined program **Smiles for Children**. This program also covers limited medically necessary oral surgery for adults covered under Medicaid (FAMIS Plus). Application and eligibility determination for this program are covered by DSS, but it is administered by DMAS, as is the case for Medicaid (FAMIS Plus) and FAMIS. Details on this program for both service recipients and providers can be found at the DMAS Web site.

Other Funding Resources: The following funding sources are generally supplementary or complimentary to the basic publicly funded insurance programs listed above. Each has its own application processes, eligibilities, and administrations unless otherwise noted. Unless otherwise indicated, funding amounts are for the entire programs and are not specific to services to individuals with disabilities.

The Virginia Department of Health (VDH) **Care Connection for Children** program manages a limited pool of funds that may be applied to certain services such as medications, diagnostic testing, therapies, durable medical equipment, and hospitalizations. Further information on services eligible for this pool of funds may be obtained from one of the six regional Centers of Excellence for Children with Special Health Care Needs. Before these funds can be used, it must be determined that no other resources, such as private or public insurance, are available. To qualify for these funds, a family must be uninsured or underinsured and have a gross family income at or below 300 percent of the federal poverty level. Financial support for Care Connection comes from Title V of the federal Maternal and Child Health (MCH) Block Grant program and Virginia General Funds.

VDH **Child Development Services** charges and payment procedures for services are discussed and determined in advance and will vary from family to family. A sliding scale based on family size and income level is available. The ten regional Child Development Clinics and satellite or field clinics are also certified Medicaid providers for covered services. Child Development Services are financed by clinic fees, Title V of the federal Maternal and Child Health Block Grant program, and state General Funds.

The VDH **Virginia Bleeding Disorders Program** manages a pool of funds that may be applied to certain services such as medications, diagnostic testing, therapies, and hospitalizations. To qualify for these funds, a family must meet financial eligibility requirements that include not having any other resources such as public or private insurance. These funds are derived from federal Title V block grants and state General Funds.

In fiscal year 2007, total funding of \$280,000 for the Virginia Health Department's (VDH) **Virginia Early Hearing Detection and Intervention** program, which was less than \$3 per individual served, came from federal sources. Of this, \$125,000 came in the form of a grant from the Health Resources and Services Administration.

Federal sources provided \$1,015,712 for the VDH **Virginia Genetics Program** in fiscal year 2007. This federal funding was dependent on matching funds of \$20,000 from the state and \$968,807 from other sources. Total funding came to \$2,004,519, which was less than \$20 per individual served.

The **Virginia Genetics Program** funds special food purchases for [children probably not buying their own food generally] children or pregnant women diagnosed as requiring treatment for phenylketonuria, a genetic disorder, through three regional Metabolic Treatment Centers. Reimbursements for foods purchased are provided from a limited pool of state General Funds. The limit on individual reimbursements is \$1,500 per person per year. Eligible families must have an income of no more than 300 percent of the federal poverty level.

Direct care services provided by the VDH **Virginia Sickle Cell Awareness Program** regional Pediatric Comprehensive Sickle Cell Clinics are funded by state General Fund appropriations. Reduced fees for services, based on a sliding scale, are charged to those who meet financial eligibility requirements. In fiscal year 2007, the state General Fund provided \$125,000 for the Sickle Cell Awareness Program, \$350,000 for the regional Clinics, and \$50,000 for Community-Based Sickle Cell Programs.

Virginia Department for the Aging (VDA): Through the individual Area Agencies on Aging, the **Virginia Insurance Counseling & Assistance Program (VICAP)** helps older persons and those with disabilities understand and gain access to private and public insurance programs. While VICAP does not provide any supplementary or complimentary funds to cover health-care needs, its services make it possible for participants to get better access to other funding sources.

Virginia Birth Injury Program: No state funds are involved in providing services to Birth Injury Fund claimants. Funding is derived from legislatively allowed sources that include participating physicians and hospital fees and assessments from nonparticipating physicians and liability insurers.

Since shortly before the publication of the 2006 Biennial Assessment, Virginia's Birth-Related Neurological Injury Compensation Fund has been the subject of substantial media and legislative focus. This attention has been directed primarily on the inability of severely injured children to obtain entry to the program and efforts further to restrict access in an effort to extend the projected financial solvency of the program. In the 2006 Assessment, the Board cited a 2003 study by the Joint Legislative Audit and Review Commission (JLARC), referenced at the end of this chapter, that made numerous recommendations for improving the program.

House Joint Resolution 646 in 2005 led to the publication in 2006 of House Document Number 11, *A Study to Establish an Economically Balanced Approach for Funding the Birth-Related Neurological Injury Compensation Fund*, also referenced at the end of this chapter. This report focused on addressing recommendations from the JLARC report regarding the implementation of the Birth Injury Fund, its program structure, and continuing actuarial deficit. These issues, particularly regarding the last-named, are too complex to be repeated in this report but they continue to be closely examined. The program's April 2007 annual financial report and the *2006 Annual Report Including Projections for Program Years 2006–2008*, submitted to the State Corporation Commission and accessible from the program's Web site, contain detailed information on past and projected receipts and expenditures. They also forecast continued actuarial deficits but report sufficient assets to continue paying claims for at least seventeen years.

F. Monitoring and Evaluation of Health Services

It is not possible to address the entire system for monitoring and evaluating the performance and responsiveness of the health-care system in this report. While people with disabilities may be an identified or likely component of the targeted populations for the health services described in this chapter, most of these services are not specific to people with disabilities. As a result, quality assurance data for these programs do not disaggregate information on services to people with disabilities. Therefore, what follows is a general description of quality assurance mechanisms related to the services described previously. More information, including detailed monitoring and complaint procedures and compliance reports, where available, may be found using the references at the end of this chapter.

Governor's Health Reform Commission: In 2007, in fulfillment of Executive Order Number 3, the Governor's Health Reform Commission was tasked with identifying ways to improve the availability, affordability, quality, and accessibility of health care in Virginia. While addressing the needs of all citizens, the Commission's Long-Term Care Workgroup focused specifically on improving long-term care options for older individuals and those with disabilities of all ages. The Commission's report is comprehensive, detailed, and identifies specific issues and recommendations for Virginia's health-care system. These are too lengthy to be repeated in this

document; however, key elements of them will be cited in the appropriate sections at the conclusion of this chapter.

Virginia Department of Health (VDH): The Department of Health has regulatory authority over certain portions of the health-care delivery and support systems. Examples of monitoring, regulatory, and quality assurance responsibilities within individual programs have already been covered in earlier sections on eligibility for and access to services. In addition, through the **Office of Licensure and Certification**, VDH licenses, monitors, and manages compliance for a wide range of public and private health-care facilities and service providers such as hospitals, outpatient clinics, certain laboratories and other testing facilities, nursing facilities, home care organizations, and hospice programs. Information on the Office's quality assurance activities relative to direct services to people with disabilities may be found in the chapters of this report covering Community Living and Institutional Supports.

The Office of Licensure and Certification is also responsible for certification of managed care health insurance plans, and, under Titles XVIII and XIX of the federal Social Security Act, the Center is the state's official Survey Agency for providers eligible for reimbursements under Medicaid and Medicare. Specific certification, inspection, monitoring, and compliance requirements vary by type of service. Details can be found at the Office's Web site, as can procedures for submitting service complaints and for their resolution.

Virginia Department of Health Professions (VDHP): Complaints or concerns about the service of health-care professionals are handled by the Department of Health Professions. Lists of covered professions, information on professional standards, complaint procedures, and forms can be obtained from the department's Web site or by contacting the staff directly. As a public service, VDHP also provides online systems for checking the current license status of health professionals, practitioners' records in the Board of Medicine's database, and the results of recent case decisions on complaints.

Department of Social Services (DSS): Quality assurance of service delivery by the DSS is the responsibility of its **Division of Quality Management**. Specific appeals regarding eligibility determinations for Medicaid (FAMIS Plus), FAMIS, and other publicly financed insurance programs by DSS, however, are handled by the administering agency, the Department of Medical Assistance Services.

Department of Medical Assistance Services (DMAS): The **Appeals Division** of the DMAS is responsible for receiving and resolving disagreements with service recipients or providers over eligibility, coverage, or payment amounts for Medicaid (FAMIS Plus), FAMIS, and other publicly funded insurance programs. Both federal and Virginia regulations stipulate requirements to ensure that all parties receive a fair and timely hearing. Details of the appeals process can be found at the DMAS Web site or may be obtained from the department directly.

Periodically, DMAS is required to conduct surveys of service recipients and providers to determine the quality and responsiveness of services provided by the publicly funded insurance

programs that it administers. DMAS also periodically reports on the success of these programs at reaching appropriate participants. Specific results regarding services specifically for people with disabilities are included in appropriate chapters of this report where available.

Virginia Birth Injury Program: Although established by the Virginia General Assembly, the Birth Injury Program is an independent organization. Oversight is provided by a seven-member volunteer board of directors appointed by the Governor, and the State Corporation Commission (SCC) has certain financial responsibilities regarding the fund that supports its operation.

The 2003 JLARC report referenced earlier under Cost and Payment made more than 30 additional recommendations for quality assurance and program improvements in areas that included: private insurance and payment of premiums; providing accessible housing; planning for lost wage benefits; improved communication with families; transportation; membership of the Board; program restructuring; the program's eligibility process, determination, and appeal mechanisms; strengthening of medical panels and procedures utilized by the panels; decision time frames; release of medical records to patients; awarding of attorneys fees; enforcement of deadlines; rigor of medical reviews of physicians and hospitals; notification to families of medical review outlines; revision of literature explaining patient rights and limitations; and referrals to the program.

G. Areas of Concern for Health Services

Since the release of the 2006 *Biennial Assessment*, Virginia has made progress in improving health services for individuals with disabilities; however, difficulties in accessing services remain. During this time, the Governor's Health Reform Commission has carefully studied the state's overall health-care system. The Board commends its work and notes that many of the issues that it addressed have also been identified, with specific regard to the health and wellness needs of persons with disabilities, in public comments received by the Board and its partners.

Without duplicating the Commission's efforts or unnecessarily citing the details in its report, the Board strongly encourages consideration of its conclusions regarding Long-Term Care; Access to Care; the Health Care Workforce, which includes direct support workers; and Quality, Transparency, and Prevention. Critical issues covered in each of those areas directly affect the lives of persons with developmental and other disabilities. Other specific findings of the Commission are cited where appropriate under the concerns described below.

While its list is not all-inclusive, the Board believes that recognizing and addressing the following concerns are critical to systems change. These concerns have been identified through a variety of means, including careful review and analysis of the source documents listed at the end of this chapter. Health and wellness concerns were also raised by participants in its six Stakeholder Roundtables and six Public Comment Forums held across the state in the spring of 2007 and in written public comments submitted during that same period. In addition, the Board receives thoughtful, well-informed feedback from its fellow participants in the Virginia Department of Health's (VDH) Health Promotion for People with Disabilities (HPPD) Task

Force on an ongoing basis. HPPD deserves special recognition for bringing together stakeholders from the public and private sectors at the state and local levels to raise awareness of health and wellness concerns for persons with disabilities and to identify and collaboratively seek solutions to persistent problems.

1. **Lack of Health Insurance:** Specifically addressed by the Health Reform Commission, concerns about this issue have not abated in any sense since the 2006 *Biennial Assessment*. Under our current health system, access to necessary care is directly dependent on the affordability of insurance. The Commission reports that 1.1 million Virginians, 15.5 percent of the total state population, are uninsured. Some individuals with disabilities are covered through their employment; nevertheless, large numbers of individuals with disabilities are unemployed, work part-time, or work full-time for employers that do not provide insurance or whose policies provide only limited coverage. Of these, some are covered by other private insurance programs, and more are covered by Virginia's public insurance programs such as Medicaid (FAMIS Plus) and FAMIS. This still leaves many others without coverage, including those whose family incomes, while modest, are sufficiently high to make them ineligible for the public insurance programs.

Higher rates of unemployment and generally lower family incomes contribute to significantly lower rates of insurance for persons with disabilities than for the general population. In addition, even those with basic health insurance may lack coverage for dental, optical, and other specialty services, and the growing complexity of insurance plans, particularly publicly funded plans, may effectively deny access to coverage. As noted by the Commission, rising demand for services under public health insurance programs, coupled with ever-rising costs for those services "may soon outpace resources." As a result, cuts in eligibility, services covered, and provider reimbursement rates are a constant concern.

2. **Lack of Dental Care:** While definitely of continuing concern, this issue has received much-needed attention since it was cited in the Board's 2006 *Biennial Assessment*. Other advocacy groups have brought this issue to the forefront, and it was identified as a critical need in the Governor's Health Reform Commission Report and in the DMHMRSAS Mental Retardation Study Report, also published in the fall of 2007. The Commission received 99 public comments related specifically to this issue.

Virginia's Smiles for Children program addresses the dental needs of children whose families qualify for public health insurance programs, but in significantly large portions of the state, there are no dentists who participate or none who will accept additional patients. Many who do participate are insufficiently trained, equipped, or willing to accommodate the special needs of patients with disabilities. Among the reasons for not participating in Smiles for Children or for serving patients with disabilities, they cite a perceived high cost for accommodations, low public insurance reimbursement rates, and associated paperwork requirements.

Participants in the October 2007 “Strong Roots for Healthy Smiles” statewide dental summit reported that obtaining dental services for children with significant health needs or behavioral issues is difficult even where dentists who participate in Smiles for Children and other insurance programs are available. When general anesthesia is required, these children must be served in hospital settings. This incurs additional costs of time and resources for dental practices, often including the transport of special equipment not available in the hospital. Dentists must also have “hospital privileges” to practice in those facilities. Reimbursements, even at the higher rates permitted under certain circumstances, are structured for standard services in a dental office and are wholly inadequate to cover the extra costs. As a result, many dentists simply chose not to provide services in hospital settings.

Dental coverage for adults under Medicaid continues to be limited to medically necessary oral surgery, much of which could be prevented through less-costly regular dental checkups. Individuals “aging out” of Smiles for Children coverage experience a sudden and dramatic decrease in covered services, often with a lifetime impact on their general health.

- 3. Shortage of Health Care Providers:** Workforce shortages, including physicians, dentists, nurses, medical technicians, direct care workers, and other allied practitioners, was identified by the Health Commission Report as a significant barrier to providing Virginians with adequate health care. This shortage often results in a complete lack of providers available and willing to treat persons with disabilities, especially when specialized training or equipment is needed and with growing numbers of practitioners declining to participate in public health insurance programs. The situation is particularly critical in rural areas and for specialties such as gynecology, obstetrics, pediatrics, and mental health where practitioners’ costs are exacerbated by high malpractice insurance rates. Despite the growing demand for their services, inadequate numbers of physicians, especially specialists, are being trained to treat persons with intellectual and developmental disabilities, and as noted in the 2006 *Biennial Assessment*, none of Virginia’s medical schools currently have a required curriculum component targeting this need.

Public clinics provide limited geographic and eligibility coverage, but frequently lack adequate accessibility for persons with disabilities, and are often inconvenient because of their limited operating schedules and long waiting times for service. Even when public clinics have capabilities to deliver specialty care, there is a perception that the quality of their care is inferior to that of private practitioners. This bias extends to both public and private institutionally based health care as well; although in some cases, quality of health care is cited as a positive attribute of the DMHMRSAS Training Centers. Pilot projects involving telemedicine are being explored partially to alleviate these problems in rural and remote areas where they are the worst, and recent news reports indicate that there have been some significant accomplishments in this area. The success of these efforts, however, is still restrained by attitudinal barriers on the part of both patients and practitioners and by lower reimbursement rates for teleservice than for in-office visits. Collectively, the lack of access to specialty providers, especially for individuals with disabilities, contributes greatly to delayed assessments, missed diagnoses, poorer health, and greater overall health-care costs.

4. **Complex Information and Lack of Outreach to Persons with Disabilities:** With increasing numbers of individuals living in communities, accessible and welcoming health and wellness opportunities are a growing requirement for effective community inclusion. Providers of public and private community health and wellness services are becoming increasingly aware of persons with disabilities as potential target populations, but, for the most part, opportunities for them to participate in health and wellness activities remain limited in number and segregated. Individuals with sensory or cognitive disabilities may also experience difficulties in gaining access to complex health and wellness information and in maintaining and providing necessary personal health records. Community service providers, information resources, and recreational facilities frequently lack training and experience in communications accommodations and access to interpretation services for both hearing-impaired and non-English-speaking populations.
5. **Lack of Physical and Operational Accessibility and Reasonable Accommodations in Health Care Settings:** Additional physical barriers to participation in health and wellness activities by people with disabilities exist because practitioners lack awareness and training in how to make appropriate accommodations or have unfounded concerns about costs and liability in providing those accommodations. Awareness and availability of assistive and adaptive technology, including accessible examination and treatment equipment, is also inadequate. Despite the provisions of the Americans and Virginians with Disabilities Acts, facilities continue to be inaccessibly constructed and operated or are difficult to reach by public transportation. Accessibility is all too often misunderstood to mean only wheelchair accessibility. These persistent physical and attitudinal barriers to access to health and wellness opportunities are especially prevalent in rural agricultural regions and in rapidly expanding urban areas.
6. **Persistent Attitudinal and Cultural Barriers:** In some Virginia communities, there is still a strong stigma attached to acknowledgement of disabilities and chronic health conditions. Especially, in rural, remote, or other close-knit communities where “everyone knows everyone else,” there are concerns that public awareness of disabilities or illness may make an individual or family more susceptible to crime, abuse, or discrimination. Among certain ethnic and religious groups, the presence of these conditions is also seen as divine punishment and a source of shame. Despite anti-discrimination laws and substantial evidence to the contrary, employers may expect excessive time off the job and higher insurance costs and block hiring or promotion of both individuals with disabilities and their family members who care for them. Fearing public disclosure of their disabilities or illnesses, persons may be reluctant to seek services or travel out of their home area for assessments or services, delaying diagnoses and limiting care options. Cultural and ethnic beliefs about disabilities and public assistance lead some individuals to resist divesting real property such as land, businesses, vehicles, and equipment considered to belong to a family rather than a single person in order to be eligible for public insurance coverage or other publicly funded assistance.

7. **Need to Improve Coordination and Continuity of Care:** Individuals with disabilities of all kinds frequently receive medical and related services from a greater number of individual providers as a direct result of their disabilities or indirectly because of co-occurring health conditions. Coordinating these providers and maintaining related health and insurance records is complicated, which creates opportunities for omissions and errors. For lower-income families, where disabilities are proportionately more common, further complications arise from gaps in service and dependence on public clinics and providers willing to accept public insurance reimbursements.

For individuals with co-occurring mental illness and intellectual disabilities, especially those with no immediate family members readily at hand, the necessity for greater sharing of information and expertise among health and disability services providers is critical, particularly with regard to the understanding and administration of medications and the provision of appropriate cognitive and behavioral supports. Case managers, disability services coordinators, and other members of an individual with disabilities' advocacy and support network may not be available during hospitalizations or in other health-care settings. Temporary guardians assigned in those settings may not understand or be fully aware of individuals' treatment and support histories and disability-related needs and concerns. The lack of interpreters and other communications accommodations previously mentioned imposes additional difficulties for those with sensory disabilities, even those who can otherwise advocate and provide information on their own behalf.

Hospitalization itself may pose additional difficulties for individuals residing in community settings. Small community residences dependent financially on reimbursement for services bundled with housing may not be able to hold a resident's space until his or her return following extended hospitalization for medical treatment. When hospitalization is no longer required, hospitals and physicians are often reluctant to discharge individuals with disabilities back into community settings, preferring nursing homes or rehabilitation facilities instead, because of concerns about medical liability or a lack of understanding of available community supports that make such institutionalization unnecessary. Subsequent extended stays in such institutions can result in loss of eligibility for home- and community-based Medicaid waivers and ultimately prevent return to community residence.

8. **Need to Ensure That Integration of Acute and Long-Term Care Services Meet the Needs of Individuals with Disabilities:** In response to both federal challenges and its own fiscal and political pressures, Virginia like many other states is involved in ongoing reform of its public health insurance programs. Pursuant to Budget Item 302ZZ of the 2006 Virginia Acts of Assembly, the Department of Medical Assistance Services (DMAS) is moving from separate, "fee for service" systems for acute and long-term care services to a unified coordinated care system that combines Medicare and Medicaid resources and relies more on managed care funded on a capitated basis. Details of the state's plans can be found in DMAS's 2006 "Blueprint for the Integration of Acute and Long-Term Care Services." Elements implemented prior to the release of this report, particularly those relevant to the state's Medicaid Waiver programs, have been covered in the Community Living Supports chapter.

9. **Challenges Resulting from Current Nurse Delegation Requirements:** Under current Virginia regulations (CFR 18 VAC 90-20-240–460), individuals who are not licensed as nurses but who are properly trained, monitored, and evaluated may perform certain procedures or tasks that would ordinarily be performed by a nurse. Currently, certain unpaid individuals, such as family members, can perform these skilled services without meeting these “nurse delegation” requirements. Other individuals, including paid personal care assistants for individuals with disabilities, may only provide these services under a plan for delegation that includes an assessment and identification of the nursing-care needs and supervision, training, and monitoring by a nurse.

With increased availability of consumer-directed services, more individuals with disabilities wish to choose who will provide these skilled services for them. Nurse delegation enables that choice; however, Medicaid State Plan and Home and Community Based Waiver procedures are unclear as to how nurse delegation must be implemented for covered services and how health providers of services via nurse delegation, in both individual and group settings where nurses are not on staff, can be reimbursed for those services. Issues of liability in the event of an error by an unlicensed individual providing a nurse-delegated service are also unclear. As a result, home health-care providers and nurses are reluctant to participate in nurse delegation of services.

H. Board Recommendations for Health Services

The concerns identified above are all important and deserving of attention, but in this report, the Virginia Board for People with Disabilities (VBPD) restricts its recommendations to areas where the need is most acute and there is the greatest potential for long-term improvements in the health and wellness of individuals with disabilities. Actions leading from these recommendations will ultimately result in an overall healthcare service system, public and private, which is more inclusive, more effective at preventing secondary problems, and more efficient in the use of public resources.

1. **Expand Availability of Dental Coverage for Individuals with Disabilities:** VBPD recommends that Virginia take immediate steps to broaden publicly funded health insurance to include dental coverage for otherwise-eligible adults with disabilities. Steps must also be taken to ensure that dental services for both children and adults with disabilities are available in all Virginia localities currently lacking them and to increase the pool of available practitioners statewide. Outreach, incentives, and improved professional training must address existing physical, operational, and attitudinal barriers. Financial incentives must include a reduction in the gap between reimbursement rates for services to individuals with disabilities covered by publicly funded insurance and those enrolled in private plans. Publicly funded insurance reimbursement rates must also be restructured to give adequate compensation to dentists for providing services that must be performed in hospital settings for individuals with medical or behavioral concerns necessitating such care. Incentives and training, accompanied by ongoing technical assistance that includes information on available assistive technologies, must be provided for both new and existing practitioners that will

enable and encourage them to make their services more accessible and welcoming to persons with disabilities.

2. **Improve Professional Training for All Health Professionals:** In addition to the targeted training for dental practitioners described above, VBPD recommends that curriculum for physicians, nurses, and all other healthcare providers, at the earliest stages of professional training and to meet continuing education requirements, be strengthened to improve the availability and quality of community care for persons with disabilities. This curriculum should address the needs of individuals with intellectual and other developmental disabilities, in particular, and foster greater understanding of the basic human and civil rights requiring outreach to and accommodations for all individuals. It should provide cross-training on mental and physical health needs and practices specifically related to disabilities, information on assistive technology, and the most up-to-date information on early diagnosis and intervention. It should also address person-centered practices, self-determination, and other “dignity of risk” issues and promote a broad understanding of the abilities and potentials of persons with disabilities. Successful models and resources for improved practitioner training, including those produced by VBPD’s sibling developmental disability network agencies in other states, exist and are available for use in Virginia contingent on the will and resources to implement them.

VBPD further believes that training and practical experience in the “medical home” concept described earlier in this chapter should become a fundamental part of initial and continuing education for health professionals. Expansion of existing pediatric medical home programs and integration of medical home concepts throughout acute and long-term healthcare for both children and adults is essential to ensuring lifetime continuity of care and person-centered planning and decision-making across service disciplines.

3. **Provide Incentives to Promote Community-Based Care:** Implementation of the recommendations above, in and of themselves, will still be insufficient to promote accessible, inclusive, and welcoming community-based health and wellness services. Additional financial, knowledge, and attitudinal barriers must be addressed to ensure that persons with the full range of disabilities have access to services without traveling long distances or reside in an institution.

VBPD recommends that existing incentives be expanded and new ones created to encourage both newly licensed and established professionals to locate inclusive practices in unserved and underserved areas of the state, such as remote rural areas and economically depressed urban areas, and to reach out to individuals with disabilities as clients. As already stated specifically for dental care, VBPD further recommends that reimbursement rates for publicly funded health insurance programs, such as Medicaid, be restructured and raised wherever necessary to establish parity with payments by private insurance plans. Similarly, situations where rate differentials may impede expansion of telemedicine should be identified and rectified, and attitudinal barriers that may discourage both providers’ and patients’ use of telemedicine should be addressed. Reimbursements must also be adequate to cover

additional equipment, educational, or operational costs incurred in providing service to individuals with disabilities and participation in publicly funded insurance programs.

- 4. Identify and Promote Best Practices for Inclusive Health and Wellness Services:** The Virginia Department of Health's (VDH) Health Promotion for People with Disabilities (HPPD) State Plan sets goals for determining the health and wellness needs of persons with disabilities and engaging new and existing providers to increase the availability and accessibility of services and promote their use. VDH has already initiated limited steps to improve its data collection and reporting, expand the outreach of its programs, and provide appropriate accommodations to make its programs more accessible to persons with disabilities. The HPPD Task Force, with VBPD's and its other partners' assistance and the limited resources available, has also begun identifying and publicizing examples of accessible, inclusive, and welcoming facilities and programs across the state, as well as programs in other states that can be emulated in Virginia. Unfortunately, while a number of accessible and welcoming programs exist, the number of inclusive programs is much smaller and significant knowledge and attitudinal barriers to their expansion exist.

VBPD recommends that these efforts be continued and expanded so that VDH and its state and local affiliates become role models for other providers in the areas of outreach, communications accommodations, and service accessibility. Resources should also be identified to support the production and dissemination of the best practices guide proposed in the HPPD state plan using VDH's own practices and the others identified by HPPD as a foundation.

- 5. Preserve Consumer Choice and Self-Direction of Health Services:** In Virginia and nationwide, the need to manage healthcare costs is leading to greater integration of acute and long-term care and the expansion of managed care. VBPD recognizes that, while these trends may potentially help to restrain rising costs, they may also inappropriately increase focus on the "medical model" for administration and funding of disability services. They may also have a negative impact on consumer choice and self-direction of services, disrupt or limit service delivery, and damage essential relationship built up between consumers and providers over many years. In the case of specialty care, they may restrict access to care that is recommended but may be more costly, reduce the number of available service providers, and unnecessarily fragment case management for health and long-term care.

To ensure that these negative outcomes do not occur, VBPD recommends close, ongoing monitoring of public and private efforts in these areas with full involvement in decision-making by persons with disabilities and their families. VBPD further recommends that the Department of Medical Assistance Services (DMAS) receives copies of all appeals of denial of service by managed-care providers and reviews them on an ongoing basis for prompt identification and resolution of systemic issues.

- 6. Maintain SCHIP Coverage:** Virginia must affirm and sustain its commitment to providing services currently covered under the national State Children's Health Insurance Program

(SCHIP). The Board recommends continued public and private vigilance and advocacy at the state and federal levels to ensure that children's healthcare remains available and affordable for Virginia's families.

Health Services Sources Referenced in This Chapter

Web Sites:

Americans with Disabilities Act: <http://www.usdoj.gov/crt/ada/publicat.htm>.

Area Agencies on Aging: <http://www.vda.virginia.gov/findservicesintro.asp>

Area Health Education Centers: <http://www.ahec.vcu.edu/>

Kaiser Family Foundation State Health Facts:

<http://www.statehealthfacts.org/profilecat.jsp?rgn=48&cat=4>

Medical Home Plus: <http://www.medicalhomeplus.org/>

“No Wrong Door”: <http://www.vda.virginia.gov/nowrongdoor.asp> **and**

http://www.seniornavigator.org/ccss_overview.php

SeniorNavigator: <http://www.seniornavigator.com/vaprovider/consumer/snConsumerHome.do>

Virginia Birth Injury Program: <http://www.vabirthinjury.com/>

Virginia Board of Medicine Practitioner Information: <http://www.vahealthprovider.com/>

Virginia Department for the Aging, Virginia Insurance Counseling & Assistance Program:

<http://www.vda.virginia.gov/vicap2.asp>

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

Library and Resource Center: <http://www.vdbvi.org/lrcservices.htm>

Low Vision Services: <http://www.vdbvi.org/LowVisionServices.htm>

Regional Offices: <http://www.vdbvi.org/OfficeList.asp>

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

Interpreter Program: <http://www.vddhh.org/IpAbout.htm>

Outreach: <http://www.vddhh.org/OrAbout.htm>

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

Arthritis Project: <http://www.vahealth.org/cdpc/arthritis/>

Baby Care: <http://www.vahealth.org/babycare/index.htm>

Bleeding Disorders Program: <http://www.vahealth.org/bleedingdisorders/index.htm>

Breast and Cervical Cancer Early Detection Program:

<http://www.vahealth.org/breastcancer/index.htm>

Bright Futures Virginia: <http://www.vahealth.org/brightfutures/>

Care Connection for Children: <http://www.vahealth.org/specialchildren/ccprogram.asp>

- Child Development Services: <http://www.vahealth.org/specialchildren/cdsprogram.asp>
- Children With Special Health Care Needs: <http://www.vahealth.org/specialchildren/>
- Congenital Anomalies Reporting and Education System (Virginia CARES):
<https://vdhems.vdh.virginia.gov/pls/vacares/vacares.main>
- Early Hearing Detection and Intervention: <http://www.vahealth.org/hearing/index.htm>
- Family Planning Program: <http://www.vahealth.org/familyplanning/index.htm>
- Genetics Program: <http://www.vahealth.org/genetics/index.htm>
- Health Promotion for People with Disabilities:
<http://www.vahealth.org/cdpc/disability/index.asp>
- Healthy Start Initiative: <http://www.vahealth.org/lovingsteps/index.htm>
- Licensure and Certification: <http://www.vdh.state.va.us/OLC/>
- Local Health Districts: <http://www.vdh.state.va.us/lhd/>
- Pediatric Screening and Genetic Services: <http://www.vahealth.org/psgs/index.htm>
- Resource Mothers Program: <http://www.vahealth.org/resourcemothers/index.htm>
- Ryan White CARE Act:
<http://www.vdh.virginia.gov/epidemiology/diseaseprevention/hcs.htm>
- School Health Program: <http://www.vahealth.org/schoolhealth/>
- Sickle Cell Awareness Program: <http://www.vahealth.org/sicklecell/index.htm>
- Strategic Plan: <http://www.vdh.state.va.us/Administration/StrategicPlan/>
- Vaccines for Children:
<http://www.vdh.virginia.gov/Epidemiology/Immunization/VFC/index.htm>
- Women, Infants & Children Program: <http://www.vahealth.org/wic/>
- Youth Suicide Prevention: <http://www.vahealth.org/civp/preventsuicideva/>
- Virginia Department of Health Professions: <http://www.dhp.virginia.gov/>
- Virginia Department of Medical Assistance Services: <http://www.dmas.virginia.gov/>
- Appeals Division: <http://www.dmas.virginia.gov/app-home.htm>
- FAMIS: <http://www.famis.org/welcome.cfm?lang=English>
- FAMIS Handbook: http://www.dmas.virginia.gov/downloads/pdfs/ch-FAMIS_handbook_English_012607.pdf
- Medicaid (FAMIS Plus) Handbook: http://www.dmas.virginia.gov/downloads/pdfs/rcp-medicaid_applicant_handbook_2007.pdf
- Medicaid (FAMIS Plus) Overview:
http://www.dmas.virginia.gov/downloads/Stats_04/Chapter_01/Overview_of_Medicaid%20-04.pdf
- Medicaid Program At a Glance: http://www.dmas.virginia.gov/downloads/pdfs/ab-Virginia_Medicaid_Program_at_a_Glance_1-06.pdf

Smiles for Children: <http://www.dmas.virginia.gov/dental-home.htm>

Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services:

Community Service Boards: www.dmhmrzas.virginia.gov/svc-csbs.asp

Regional Community Service Centers at State Training Centers:

Northern Virginia (NVTC): www.nvtc.dmhmrzas.virginia.gov/RCSC.shtml

Central Virginia (CVTC): www.cvtc.dmhmrzas.virginia.gov/new_page_1.htm

Southeastern Virginia (SEVTC):

www.sevtc.dmhmrzas.virginia.gov/RCSC/RCSC.htm

Southside Virginia (SVTC): www.svtc.dmhmrzas.virginia.gov/vrcdd.htm

Southwestern Virginia (SWVTC): www.swvtc.dmhmrzas.virginia.gov/rcsc.htm

Virginia Department of Social Services: www.dss.virginia.gov

Division of Quality Management: <http://www.dss.virginia.gov/division/qm/index.html>

Medicaid and FAMIS Programs:

http://www.dss.virginia.gov/benefit/me_famis/index.html

Medicaid Appeals Process:

http://www.dss.virginia.gov/files/division/bp/me_famis/policy/manual/m16.pdf

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http://www.dss.virginia.gov/files/about/reports/agency_wide/annual_statistical/asr2007_master2.pdf.

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<http://leg1.state.va.us/cgi-bin/legp504.exe?000+cod+51.5-1>.