

**Protection and Advocacy for Developmental Disabilities (PADD)  
Annual Program Performance Report (PPR)**

**Reporting Period: October 1, 2008 through September 30, 2009**

<b>Section I — Designated Agency Identification</b>	
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**Section 2 — Individual Clients Served**

This section is for reporting of persons with developmental disabilities who received individual advocacy addressing at least one disability-related problem. Do not report the same individual more than once even if they received multiple services, and do not include individuals who were only represented as part of a group or class action.

<b>A. Number of Individual Clients (Persons with Developmental Disabilities Receiving Individual Advocacy)</b>	
1. Number of clients receiving advocacy at start of fiscal year:	58
2. Number of new/reviewed clients represented during fiscal year:	89
<b>Total</b>	<b>147</b>
3. If program income was used to supplement the PADD allotment for the reporting period, estimate the number of individuals served as a result of program income dollars:	
4. Number of individuals requesting individual advocacy and who are eligible under the PADD program but did not receive such	

<b>B. Number of Case Problems* of Individual Clients</b> *This number may be more than the total number of clients serviced since each client may have more than one presenting problem to be addressed.	180
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<b>C. Number of Individual Clients by Age</b>	
0-2	0
3-4	3
5-22	62
23-59	68
60 and over	14
<b>Total</b>	<b>147</b>

<b>D. Number of Individual Clients by Sex</b>	
Male	103
Female	44
<b>Total</b>	<b>147</b>

<b>E. Racial/Ethnic Background of Individual Clients</b> Data is self-reported. Select only one category for each client.	
Asian	3
Black, not Hispanic/Latino origin	24
Hispanic/Latino	1
North American Indian or Alaskan Native	
Pacific Islander	
White, not Hispanic/Latino origin	112
Multi cultural (identified with more than one of above)	6
Information Not Provided	1

<b>Total Clients</b>	147
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**F. Number of Individual Client by Geographic Location**

<b>Number of clients living out of state</b>	In- State	Out-of- State
<b>List states include number of clients living in each state:</b>		
<b>Urban (metropolitan area with population of 50,000 or more):</b>	62	0
<b>Rural (all other):</b>	85	0

**Data by County (see instructions; use additional space as needed). Please provide the following:**

	County Name	Total Population	Number of Individual Clients
	Albemarle(U)	92,035	1
	Amherst (R)	32,239	11
	Arlington (U)	199,776	3
	Bristol City ( R )	17,496	3
	Campbell (U)	52,667	1
	Caroline (R)	26,731	1
	Carroll (R)	29,450	27
	Charlottesville City (R)	40,315	1
	Chesapeake City (U)	220,560	11
	Chesterfield (U)	296,718	6
	Culpeper (R)	44,622	3
	Danville City ( R )	45,586	1
	Dinwiddie (R)	25,695	15
	Fairfax City (R)	22,422	2
	Fairfax (U)	1,010,443	8
	Franklin City ( R )	8,800	1
	Frederick (U)	71,187	5
	Fredericksburg City (R)	21,273	2
	Giles (R)	17,403	1
	Goochland ( R )	20,085	1
	Henrico (U)	284,399	6
	Henry (U )	56,208	1
	Hopewell City (R)	22,731	1
	Lee (R)	23,787	6
	Loudoun (U)	268,817	2
	Lynchburg City (U)	67,721	2
	Mecklenburg (R)	32,381	1
	Montgomery (U)	84,541	2
	Newport News City (U)	178,281	1
	Norfolk City (U)	229,112	2
	Northampton	13,609	1
	Petersburg City (R)	32,445	1
	Prince William (U)	357,503	2

Richmond City (U)	192,913	1
Roanoke (U)	90,482	2
Shenandoah (R)	40,051	2
Smyth (R)	32,506	1
Southampton (R)	17,814	1
Spotsylvania (U)	119,529	4
Stafford (U)	120,170	5
Staunton City (R)	23,334	1
Sussex (R)	12,249	1
Tazewell (R)	44,608	2
Warren (R)	36,102	4
Waynesboro City ( R)	21,454	1
Westmoreland ( R)	17,188	1
Winchester City ( R)	25,265	2

<b>G. Clients' Living Arrangements</b>	
<b>Independent</b>	3
<b>Parental or other Family Home</b>	64
<b>Community Residential Home (e.g. supervised apartment, semi-independent, halfway house, board &amp; care, small group home 3 or less)</b>	9
<b>Foster Care</b>	1
<b>*Nursing Home (includes ICF, SNF, etc.)</b>	
<b>*Public (State Operated) Institutional Living Arrangement (e.g., hospital treatment center/school or large ICF/MR group home more than 3 beds)</b>	68
<b>*Private Institutional Living Arrangement (e.g. hospital or treatment center, school group home more than 3 beds)</b>	2
<b>*Legal Detention/Jail/Prison/Detention Center</b>	
<b>Homeless</b>	
<b>*Federal Facility (List)</b>	
<b>Other</b>	
<b>Total Client Cases by Living Arrangement</b>	147

(\*Is considered an institution for the purposes of completing Section III A-1)

<b>H. Individual Clients' Disability</b>	
Identify the client's primary disability. This is the disability which directly impacts or allows the individual to be considered developmental disabled and results in the need for advocacy.	
<b>Autism</b>	33
<b>Cerebral Palsy</b>	19
<b>AIDS/HIV</b>	
<b>Epilepsy</b>	
<b>Mental Illness</b>	3
<b>Mental Retardation</b>	80

<b>Muscular Dystrophy</b>	1
<b>Spina Bifida</b>	5
<b>Learning Disabilities</b>	
<b>Traumatic Brain Injuries (TBI) and other head injuries</b>	1
<b>Tourette Syndrome</b>	
<b>Visual Impairment/Blind</b>	2
<b>Hard of Hearing/Deaf</b>	1
<b>Other Physical/Orthopedic*</b> (1 muscular or skeletal; 1 neurological)	2
<b>Other Emotional/Behavioral*</b>	
<b>Other Intellectual*</b>	
<b>Total Disabilities</b>	147

**\*Breakout of Other Disability**

### Section 3. Case Problem Areas (Complaints) of Individual Clients Served

This is the total number of problems addressed by the PADD program and collected at case closure. This will allow the PADD program to better determine the outcome of its work. This can be more than the number of problems presented upon intake that is the total number reported in Section II B.

#### A. The outcome of problems addressed for Individual Clients

1. Number of persons with developmental disabilities living in institutions* served by the P&A whose complaint of abuse, neglect, discrimination of their rights was remedied by the P&A. (*see living arrangements to determine definition of institution)	47
2. Number of persons with developmental disabilities living in the community who were served by the P&A and whose complaint of abuse, neglect, discrimination of their rights was remedied by the P&A during the course of the plan year.	64

#### B. Types of problems addressed by areas of emphasis

1. Quality Assurance including abuse, neglect & other violations of rights	59
2. Education and early intervention	41
3. Child care	
4. Health care	18
5. Employment	5
6. Housing	6
7. Transportation	3
8. Recreation	9
<b>Total Case Problem Areas of Individual Clients Addressed upon closure</b>	<b>141</b>

#### C. Reasons for Closing Individual's Case Files:

1. Issues resolved partially or completely in the individual's favor	127
2. Other representation found	
3. Individual withdrew complaint	3
4. Appeals were unsuccessful	
5. PADD services not needed due to individual's death, relocation, etc.	
6. PADD withdrew because individual would not cooperate	7
7. PADD unable to take case because of lack of resources	
8. Individual's case lacks legal merit	4

#### D. Intervention Strategies Used in Serving Individuals (List the highest level of Interventions used by PADD prior to closing each case file.)

1. Technical assistance in self-advocacy	22
2. Short-term assistance	35

<b>3. Investigation/monitoring</b>	36
<b>4. Negotiation</b>	44
<b>5. Mediation/alternative dispute resolution</b>	1
<b>6. Administrative hearings</b>	
<b>7. Litigation</b>	3

<b>E. Satisfaction of Individuals Served</b>	
<b>1. Number of satisfaction surveys distributed</b>	20
<b>2. Number of satisfaction surveys returned during the year (may not be the same number sent out.)</b>	12
<b>3. Of the total number of surveys returned, indicate how many individuals rated their overall satisfaction with PADD in the following ways:</b>	
<b>a. satisfied</b>	12
<b>b. not satisfied</b>	0
<b>4. Number of client grievances filed under the client grievance procedure</b>	0

## Section 4: Interventions on Behalf of Groups of Clients

### A. Summary Information

Type of Intervention	Number of Groups	Potential # Individuals Impacted	Concluded Successfully	Concluded Unsuccessfully	Pending
<b>Group Advocacy</b>	1--VA special education students	175,730	X		
	2- - people with DD using home health or hospice services	85,000			X
	5- - state operated ICF/MR residents	1300			X
<b>Investigations</b>	1--quality of DBHDS internal abuse & neglect Investigation for ICF/MR	1300			X
<b>Monitoring</b>	5--State-operated ICF-MR	1300			X
<b>Court-Ordered Monitoring</b>	Not applicable				
<b>Systemic or Class-Action Litigation</b>	1--VOPA vs. Reinhard, et al	3000+			X
	1--Arc v. Kaine	160			X
<b>Total</b>	16	267,790	1		6

### B. Group Advocacy:

#### 1. What are the major issues addressed?

VOPA provided public comment on the proposed special education regulations to ensure that the proposed changes were as protective as possible for students. Our comments were accepted specifically in the areas of educational evaluations and Due Process. The regulations initially put forward by the Department of Education limited the students' safeguards and compromised the integrity of due process.

VOPA has been working with the Virginia Department of Health on two (2) regulatory packages. One is for home health services and the other is hospice services. VOPA's intent in both packages is to balance individual safety with self-

determination. VOPA will continue to comment as the regulatory packages proceed through the administrative process.

The DD Network, the Arc and 100 community organizations issued a “Call for Reform” to Virginia policy makers. The Call for Reform advocates for a re-visioning of the DD service delivery system in Virginia from an institution-based service delivery system to an integrated community-based system.

**2. Which groups are likely to be affected?**

Residents of state operated ICF/MRs, people with DD living in the community receiving home health services or hospice services, and children with DD using special education services.

**3. What have been the major outcomes during the fiscal year?**

Please see above regarding special education regulation changes. VOPA’s recommendations about the other sets of administrative regulation packages are either included in the regulation packages or are being considered for technical assistance documents that the Department of Health is revising for its providers. VOPA’s recommendations centered on enforcing the ADA and maximizing consumer choice, decision making opportunities and fostering a social versus a medical model for service delivery.

**4. How do these outcomes contribute to the long-term objectives as stated in the Statement of Objectives and Priorities (SGP)?**

All 3 regulation packages are related to safeguarding both the rights and welfare of the recipients of services. All 3 packages address preventing abuse and neglect, maximizing the individuals’ rights to exercise choice and decision-making, and tenets of integration.

Collaborative work with the DD Network and the Arc on Call for Reform supports VOPA’s objectives in the areas of abuse and neglect in institutions, equal access to government services and community integration.

**C. Full Investigation**

**1. What are the major areas of investigation?**

VOPA is investigating the quality of internal abuse/neglect investigations conducted by the state operated ICFs/MR.

**2. Which groups are likely to be affected?**

Residents of the state-operated ICFs/MR

**3. What have been the major outcomes during the fiscal year?**

Through advocacy including complaints through the human rights complaint system, VOPA highlighted provisions of the performance contract with community services boards that appear to be intended for the benefit of patients awaiting discharge. The investigation found that the DBHDS did not have a

practice of enforcement. The performance contract defines DBHDS' standards for discharge planning practices through a set of admission and discharge protocols. VOPA's investigation identified widespread non-compliance with these standards among CSBs and state-operated institutions. VOPA obtained policy and procedure changes, staff training and other reforms to bring a state-operated ICF/MR into compliance with the protocols. VOPA will advocate for systemic change statewide. Additionally, DBHDS undertook a long-postponed effort to bring its discharge protocols up to date.

**4. How do these outcomes contribute to the long-term objectives as stated in the Statement of Objectives and Priorities?**

Because Virginia still has state-operated ICF/MR and intends to rebuild and refurbish them, these outcomes are critical to identifying abuse of the system and neglect of the individuals in their charge. VOPA foresees these types of investigations to be necessary year after year due to the institutional bias within the State at both the Executive and Legislative branch levels.

**D. Monitoring**

**1. What are the major areas of non-court ordered monitoring?**

There are 5 state-operated ICFs/MR in Virginia. VOPA monitors conditions several times a month, investigating trends, following upon injuries, collecting policies and other systemic information in addition to being available to residents. This monitoring may include providing rights information and some short-term assistance services. Staff consistently identify possible abuse and neglect by reviewing all Critical Incident Reports. Staff consistently prepare monthly summaries of CIRs, quarterly trend analyses of CIRs, quarterly reports on use of administrative investigations, and other analyses as needed for use in institution monitoring and to identify possible patterns of abuse or neglect.

**2. Which groups are likely to be affected?**

Residents of state operated ICFs/MR.

**3. What have been the major outcomes during the fiscal year?**

Identification of abuse and neglect that the internal investigation system either does not recognize or fails to identify.

**4. How do these outcomes contribute to the long-term objectives as stated in the Statement of Objectives and Priorities?**

These efforts are directed specifically at freedom from abuse and neglect and increased community integration.

**E. Court Ordered Monitoring- - Not applicable**

**1. What are the major areas of court ordered monitoring?**

**2. Which groups are likely to be affected?**

3. **What have been the major outcomes during the fiscal year?**
4. **How do these outcomes contribute to the long-term objectives as stated in the Statement of Objectives and Priorities?**

## **F. Systems or Class Action Litigation**

### **1. What are the major areas of litigation?**

VOPA seeks access to peer review records that it is entitled to per federal law. VOPA sought the records as part of investigations into a death & a serious injury at a state-operated ICF/MR. DBHDS refused to provide the records & VOPA sought judicial relief. The case is pending a decision on VOPA's petition of certiorari with the U.S. Supreme Court. VOPA represents The Arc of Virginia, Inc. in a lawsuit against Governor Kaine et al. Virginia plans to build a new segregated institution to "replace" SEVTC, a state operated ICF/MR. Virginia plans to build & fully populate a new 75-bed institution on the current segregated compound. The Arc contends the plan & the Budget Item that precipitated it violate the ADA & Section 504. It puts members at risk of being placed in the new institution in lieu of a community setting. The Arc alleges the plan & Budget Item are also unconstitutional.

### **2. Which groups are likely to be affected?**

Residents of state operated ICF/MRs.

### **3. What have been the major outcomes during the fiscal year?**

Both litigation efforts are on-going.

### **4. How do these outcomes contribute to the long-term objectives as stated in the Statement of Objectives and Priorities?**

These efforts are directed specifically at freedom from abuse and neglect and increased community integration. The ultimate stake here is much larger, however, in that the respondent has chosen to defend on the basis of sovereign immunity and alleging that their internal investigations are protected by the confidentiality of professional peer reviews.

## **G. Other Systems Change Activities**

### **1. What are the major areas of systems change activities?**

VOPA & advocacy groups, including independent living centers, the long-term care ombudsman, the DD council and poverty-rights groups worked collaboratively to educate policy makers on legislative, budgetary and regulatory issues. Together we advised policy makers on legislation setting a statute of limitations on special education appeals, on the need to eliminate Medicaid Waiver waiting lists, on guardianship rights and abuses, and on the need to maximize resources for community housing. See section 9 for further activities.

### **2. Which groups are likely to be affected?**

PADD eligible adults receiving publicly funded services

**3. What have been the major outcomes during the fiscal year?**

Policy changes occurred as a result of VOPA's work in educating policy makers in conjunction with other advocacy entities and advocates.

**4. How do these outcomes contribute to the long-term objectives as stated in the Statement of Objectives and Priorities?**

These outcomes are directly related to VOPA's annual objectives to educate policy makers about community integration issues for people with disabilities.

**5. Number of people with disabilities impacted?**

267,790

<b>Section 5: Non Case Directed Services</b>	
<b>A. Information and Referral Services (see glossary for definition (Individual Non Case I&amp;R) Total I&amp;R</b>	2567

<b>B. Public Education and Training Activities (see glossary for definition)</b>	
1. Number of Education / Training Activities Undertaken	22
2. Total number of persons trained (approximate)	764

<b>C. Information Dissemination Activities</b>	Number of Items
1. Radio/TV appearances	0
2. Newspaper articles	0
3. PSAs/videos/films/etc. aired	0
4. Reports disseminated	0
5. Publications disseminated	3
6. Information about P&A disseminated (include general training/outreach or presentations not included in training activities)	795
7. Number of hits on Website	20,864
8. Describe other media activities: training flyers and announcements posted by other entities	7

<b>Outcome Statement:</b>	
Number of persons who received information about the P&A and its services	764
Number of persons with disabilities (or their family members) who received education or training about their rights, enabling them to be more effective self-advocates	642

<b>D. Number of Consumers on Board by type:</b>	<b>Governing Board</b>	<b>Advisory Council</b>
Primary consumers	2	
Secondary consumers	11	
Other consumers with disabilities		
Total people	13	

<b>E. Racial/Ethnic Involvement in P&amp;A Organization</b>	<b>P&amp;A Staff</b>	<b>Governing Board</b>	<b>Advisory Council</b>
African American	5	3	
Hispanic American			
Asian American	1		
Native American			

<b>Other</b>	<b>27</b>	<b>10</b>	
<b>Total</b>	<b>33</b>	<b>13</b>	

**Does the PADD program utilize volunteers? If so how?** no

## Section 6: Outcomes of Priorities and Objectives

### 1. **Priority #1 - -People with Disabilities are Free from Abuse and Neglect**

#### 2. **Indicator #(1):**

VOPA will review all reports of death that it receives and will investigate DBHDS' internal death review policies and practices as well as the practices of the medical examiner and practices relating to autopsies, to determine whether the practices are sufficient to protect residents from harm. Two deaths will be selected for investigation where abuse or neglect is suspected.

**Indicator is:** partially met; work is ongoing

**If “Met or Partially Met” was checked, summarize details, including one or two cases that exemplify the success; for fully met goals, the example case(s) should be successfully closed.**

VOPA reviewed all received reports of deaths at a state-operated ICF/MR including facility compliance with requirement to notify Medical Examiner, reviewed Medical Examiner policy regarding jurisdiction over deaths at state facilities and reviewed Medical Examiner data reflecting reports of death from DBHDS-operated facilities. VOPA identified regional differences with regard to Medical Examiner response to reports of death at DBHDS facilities. Work in this area is on-going.

#### 3. **List other outcomes realized (if applicable)** Not applicable, work is ongoing.

#### 4. **Explain whether pursuing this priority involved collaborative efforts by other entities. If do, describe this collaboration:**

VOPA requested and received data from the medical examiner office.

#### 5. **If this was addressed through individual advocacy, provide the number of cases handled under this priority**

4 investigations- - all ongoing

#### 6. **If this priority addresses systemic advocacy or capacity building of the service delivery system for persons with developmental disabilities, please describe how including indicating if any were class actions.**

VOPA's review of DBHDS' internal death review policies and practices and the practices of the medical examiner and practices relating to autopsies, may help to determine whether the practices are sufficient to protect residents from harm.

#### 7. **Was this priority targeted to under/unserved and minority populations? If so please describe whether or not services to the targeted population resulted in an increase in clients served.**

VOPA considers residents of the state-operated ICF/MRs to be underserved in the areas of rights protection and protection from abuse and neglect.

**8. Describe at least one case summary that demonstrates the impact of the priority.**

VOPA is conducting investigations into the deaths of four (4) individuals who were residents of ICF/MRs. One involves an apparent adverse reaction to psychotropic medication which the authorized representative was opposed to using to manage behavior instead of an appropriate behavior plan. Another investigation involves the withholding of medical care based upon the religious beliefs of a substitute decision maker. The individual died of aspiration pneumonia after a g-tube was not placed. The authorized representative opposed treatment.

**9. Rounding off to the nearest hundred dollars, how much of this year's grant or award or its program income was spent on this priority? \$39,579**

**10. Will this priority be continued in the next fiscal year? Yes**

**1. Priority #1 - -People with Disabilities are Free from Abuse and Neglect**

**2. Indicator #(2):**

VOPA will combat abuse and neglect in community settings. This will be done by conducting investigations, developing trainings, assessing emergency response plans, systemic advocacy, educating policy makers and collaboration.

**Indicator is:** Partially met; work is ongoing

**If “Met or Partially Met” was checked, summarize details, including one or two cases that exemplify the success; for fully met goals, the example case(s) should be successfully closed.**

VOPA is investigating 4 allegations of suspected abuse or neglect of individuals with disabilities in the community. The allegations include the misuse of seclusion-like interventions and restraint, failure to provide appropriate discharge planning and unsafe transportation.

VOPA helped a client wanting discharge from an ICF-MR to a community based waiver placement. VOPA advocated for our client to be discharged to a sponsored residential placement of the client's choosing. Discharge planning included employment, housing, and accessing assistive technology and environmental modifications via Virginia's Money Follows the Person waiver. Our client has successfully been discharged and reports indicate he is very satisfied with the move.

VOPA evaluated whether the Department of Medical Assistance Services (DMAS) provides appropriate Medicaid transportation to people with disabilities. VOPA reviewed complaints by clients, reports submitted by Logisticare (DMAS contractor), and did trend analysis. VOPA found inaccuracies or inconsistencies in DMAS and Logisticare material and asked for more information. The reviewed material strongly suggests that DMAS and Logisticare do not provide appropriate services. VOPA convened a conference with DMAS and suggested several ways it could improve its performance and ways DMAS and VOPA could work together on this issue. DMAS has refused to take the steps suggested by VOPA. VOPA will carry this objective over to FY2010 in order to conduct a state-wide investigation, in collaboration with other advocacy organizations, to determine whether Logisticare and DMAS provide appropriate services. If they do not, VOPA will take appropriate steps as events warrant.

**3. List other outcomes realized (if applicable)**

VOPA reviewed the regulatory requirements for community based programs' disaster response plans to determine whether they provided sufficient protection from harm. VOPA found that the State Nursing Facilities regulations require an emergency plan but are lacking in detail. Federal regulations also require nursing

facilities to develop plans. VOPA found that VDH does not routinely survey these plans as part of their work for CMS; it is only required for new licensees. VOPA concluded that although the regulations offer sufficient guidance on development of disaster response plans, there is a need for increased consumer involvement in all levels of planning. Also, interagency collaboration to enhance training and technical assistance is needed. The Secretary of Health and Human Resources has designated VDH to coordinate Virginia's efforts regarding emergency preparedness for people with disabilities and other special needs and VOPA is an active participant in this process. VOPA concluded that the current regulations offer sufficient guidance on development of disaster response plans.

**8. Describe at least one case summary that demonstrates the impact of the priority.**

VOPA's client, who has cerebral palsy, uses a wheelchair and relies upon Logisticare for medical transportation. VOPA represented the client as part of its systemic investigation into Logisticare. The client complained that the Logisticare contractor transporting him was inaccessible, used vehicles with faulty brakes and on several occasions failed to properly strap down the client's wheelchair. In addition to VOPA's investigation, VOPA submitted a complaint for the client to the Department of Medical Assistance Services. VOPA confirmed that DMAS had validated the complaint and properly addressed the problem. Like all of the cases in VOPA's investigation, this case provided VOPA with data and information regarding Logisticare as a whole and about DMAS' complaint system. This data will be used, going forward, in VOPA's continuing investigation of Logisticare.

**9. Rounding off to the nearest hundred dollars, how much of this year's grant or award or its program income was spent on this priority? \$46,450**

**10. Will this priority be continued in the next fiscal year? yes**

**1. Priority #1 - -People with Disabilities are Free from Abuse and Neglect**

**2. Indicator #(3):**

VOPA will combat abuse and neglect in institutions. This will be done by investigating, providing individual case level advocacy, systemic advocacy, facility monitoring, educating policy makers, providing residents training and collaboration.

**Indicator is:** Met

**If “Met or Partially Met” was checked, summarize details, including one or two cases that exemplify the success; for fully met goals, the example case(s) should be successfully closed.**

VOPA has initiated twelve (12) investigations into complaints or incidents where abuse or neglect is suspected in institutional settings. The incidents include a spiral fracture inflicted during a “staff intervention,” injuries during “time out” and restraint episodes, misuse of PRN medication, a severe burn during bathing, and peer-on-peer assault.

VOPA concluded a comprehensive investigation of a severe scalding incident at a state-operated ICF/MR and will be issuing a report citing deficiencies in the institution’s response to the incident.

VOPA conducted an investigation into an incident at a state-operated ICF/MR in which staff were turning off a resident’s power chair allegedly due to behavior problems. As a result of the investigation the institution acknowledged that turning off the chair constituted restraint. Changes were made to the resident’s program plan to prevent inadvertent restraint or "time out" (seclusion) by interference with the wheelchair and institution staff were retrained on wheelchair and restraint procedures.

**3. List other outcomes realized (if applicable)**

VOPA provided public comment on the DBHDS regulatory package addressing voluntary admissions to state-operated ICFs/MR. VOPA identified sections of the regulations that were in violation with the DBHDS Human Rights regulations. VOPA also noted that the Medicaid State Plan assures individuals’ rights to ICF/MR services, not to a building. DBHDS informed VOPA they will take this and other VOPA recommendations to the DBHDS State Board for consideration.

**8. Describe at least one case summary that demonstrates the impact of the priority.**

A resident of a state-operated ICF/MR who is blind asked VOPA to investigate and resolve bathroom hazards causing injury. VOPA conducted a preliminary inquiry of our client’s injury, followed by a full investigation of rusty metal hazards in bathrooms in client's cottage. VOPA confirmed hazardous rusty metal hazards in both bathrooms in the cottage. VOPA advocated for corrective measures and

negotiated and monitored an implementation plan. VOPA obtained individual and facility-wide corrective measures including new wheels and fenders for the client's rolling walker and a facility-wide survey was conducted to identify rusty metal hazards in bathroom areas. Eight hazards were identified and remedied.

**9. Rounding off to the nearest hundred dollars, how much of this year's grant or award or its program income was spent on this priority? \$164,911**

**10. Will this priority be continued in the next fiscal year? yes**

**1. Priority #1 - -People with Disabilities are Free from Abuse and Neglect**

**2. Indicator #(4):**

VOPA will combat physical abuse in juvenile facilities by providing training on abuse and neglect and conducting investigations.

**Indicator is:** Partially met

**If "Met or Partially Met" was checked, summarize details, including one or two cases that exemplify the success; for fully met goals, the example case(s) should be successfully closed.**

VOPA reviewed each CIR received from the state-operated ICFs/MR however, none involved adolescents with DD. VOPA routinely conducts monitoring of the state-operated ICFs/MR which includes educating residents and staff regarding residents' rights and identifying and reporting abuse and neglect.

**3. List other outcomes realized (if applicable)**

VOPA reviews the annual Medicaid survey of each of the five state operated and 30 locally or privately run ICFs/MR in order to identify issues relating to adolescent residents.

**8. Describe at least one case summary that demonstrates the impact of the priority.** VOPA received no specified PADD eligible complaints for this priority.

**9. Rounding off to the nearest hundred dollars, how much of this year's grant or award or its program income was spent on this priority? \$12,712**

**10. Will this priority be continued in the next fiscal year? yes**

**1. Priority #2 - - Children with Disabilities receive an appropriate education**

**2. Indicator #(1):**

VOPA will address children with disabilities who are denied special education eligibility due to inappropriate evaluation or assessment by providing trainings including outreach to the Spanish-speaking community, representing 15 children including children in foster care or from Spanish speaking families, and systemic

advocacy.

**Indicator is:** Met

**If “Met or Partially Met” was checked, summarize details, including one or two cases that exemplify the success; for fully met goals, the example case(s) should be successfully closed.**

VOPA advocated for children to be provided with appropriate special education services. VOPA represented two (2) clients in foster care regarding special education services. One case involved a young man aging out of foster care who was being denied adequate educational and transition services. With VOPA's advocacy, the client obtained a successful vocational placement before he left the foster care system. A second case involved a client from Sudan who was in foster care and had been denied SPED services for 3 years. VOPA advocated for a full neuro-psychological evaluation, which was agreed to by his foster care agency. The client was subsequently declared emancipated and decided to leave school and begin employment in the community.

**3. List other outcomes realized (if applicable)**

VOPA developed and presented trainings on 3 distinct stages of the IEP process to 9 groups, including parents, advocates and school personnel. The trainings were very well received and resulted in numerous requests that VOPA provide the training to parents and advocates throughout the Commonwealth. VOPA edited the material to include information on voting, Medicaid, and traumatic brain injury issues. At the trainings, materials on the new special education regulations were disseminated.

**4. Explain whether pursuing this priority involved collaborative efforts by other entities. If do, describe this collaboration:**

VOPA was invited by DMAS and DBHDS to participate in a workgroup addressing early intervention services for children ages 0-3 years old. VOPA's role was representing the rights of these very young children related to both Medicaid services and Part C services. Although the workgroup's focus was on transitioning providers from billing Part C to billing Medicaid, DMAS and DBHDS both recognized that this could have implications on the children and family receiving the early intervention services. With a provider-heavy workgroup, VOPA advocated for streamlined processes and plain language materials for families. We felt that these would help families to not “fall between the cracks” as the providers shifted billing systems.

**5. If this was addressed through individual advocacy, provide the number of cases handled under this priority 26**

**6. If this priority addresses systemic advocacy or capacity building of the service delivery system for persons with developmental disabilities, please**

**describe how including indicating if any were class actions.**

VOPA proposed changes to sections of the regulations that would have negatively impacted children. As a result, the independence of Due Process Hearing Officers was ensured, transition age was lowered to 14, schools must now consider benchmarks and short term objectives, and schools may not cease special education services without consent of parents.

**7. Was this priority targeted to under/served and minority populations? If so please describe whether or not services to the targeted population resulted in an increase in clients served.**

VOPA continued its outreach to the Spanish-speaking community by reviewing Census Bureau data to identify areas with a significant Hispanic population, and by identifying Virginia-based organizations with a focus on education issues serving Virginia's Spanish-speaking population. These include organizations offering ESL (English as a Second Language) classes and others such as PEATC. We also identified Spanish newspapers and radio stations along with contact information for these media outlets. VOPA presented special education training to ten Spanish-speaking parents at an elementary school PTA and provided special education materials in Spanish to eleven (11) other PTA organizations in areas with a significant Hispanic population. We also met with members of the Southwood Project Coalition (Richmond area) including the Bilingual Parent Liaison for the Richmond City Schools and the Director of the Southwood neighborhood "Resource Center." We also met with the Southwood Boys/Girls Club staff and provided written information about VOPA and about special education, including Spanish-language material available.

**8. Describe at least one case summary that demonstrates the impact of the priority.**

VOPA represented a child with Asperger's Syndrome whose IEP required a 1:1 aide for the duration of his school day. The School eliminated the 1:1 while our client was in the hospital, and did not reinstate the 1:1 upon his return to school. After multiple unsuccessful IEP meetings, VOPA assisted our client draft and file Virginia Department of Education Complaint against school district for refusing to provide services consistent with the IEP. VDOE determined the school to be in noncompliance with the IEP and instructed the school to provide the 1:1 services, as well as compensatory education services as agreed to by the IEP team.

**9. Rounding off to the nearest hundred dollars, how much of this year's grant or award or its program income was spent on this priority? \$83,761**

**10. Will this priority be continued in the next fiscal year? yes**

**1. Priority #2 - - Children with Disabilities receive an appropriate education**

**2. Indicator #(2):**

VOPA will protect the rights of children with disabilities to receive an appropriate

education by representing children who at risk of or have been suspended due to inadequate BIPS or FBAs, by representing 5 children and monitoring DOE mediators.

**Indicator is:** Met

**If “Met or Partially Met” was checked, summarize details, including one or two cases that exemplify the success; for fully met goals, the example case(s) should be successfully closed.**

VOPA represented 12 children who were at risk of suspension due to inadequate Behavioral Intervention Plans (BIPs) or Functional Behavioral Assessments (FBAs). In all cases, VOPA requested either new assessments or independent educational assessments to determine the validity of the school’s findings. In one case, the child was placed in a school that did not follow his IEP, resulting in him having behavior problems that put him at risk of suspension. This case resulted in a DOE complaint where the school was found to have violated the child’s rights and the child received compensatory services.

**3. List other outcomes realized (if applicable)**

In one case, the parent complained that the school would not provide an FBA for a child who had been suspended. VOPA advocated for an appropriate FBA. The new assessment was done and an appropriate plan was implemented. The student’s behavior was found to be a manifestation of his disability. In another case, VOPA advocated for a child to be moved to a new placement as part of a behavioral intervention plan. The school agreed. In a 3rd case, VOPA advocated for a child to receive a new FBA because the prior one did not result in an effective BIP. After the school conducted a new FBA, a new BIP was created and implemented successfully.

VOPA did not represent any children who were suspended or at risk of suspension in Due Process hearings as all cases that could proceed to due process were resolved amicably by the school districts.

VOPA did not discover or encounter any instances where VDOE mediators engaged in improper *ex parte* communication.

**8. Describe at least one case summary that demonstrates the impact of the priority.**

A mother asked for help getting an appropriate FBA, BIP, and 1:1 aide for her son with Cerebral Palsy. He would sometimes roll on the classroom floor for hours per day, and had other behaviors resulting in a 3 day suspension. After the LEA was notified of VOPA’s involvement, client immediately received an FBA and BIP which resulted in improved behavior, increased safety and greater learning. The BIP has been implemented and parents are satisfied. They see good results and feel that the new behavioral supports and techniques that have been implemented are working.

9. **Rounding off to the nearest hundred dollars, how much of this year's grant or award or its program income was spent on this priority?** \$28,997

10. **Will this priority be continued in the next fiscal year?** yes

1. **Priority #3 - - People with Disabilities have Equal Access to Government Services**

2. **Indicator #(1):**

VOPA will advocate for services and supports to enable individuals to move into the community through systemic advocacy and representing individuals ready to move to the community.

**Indicator is:** Met

**If "Met or Partially Met" was checked, summarize details, including one or two cases that exemplify the success; for fully met goals, the example case(s) should be successfully closed.**

VOPA is representing four (4) individuals in their efforts to move into less restrictive settings in the community from state-operated ICFs/MR.

VOPA presented training on social security benefits planning for residents and their family members at a state-operated ICF/MR.

3. **List other outcomes realized (if applicable)**

3 cases are still ongoing. While representing the 4th client, VOPA noted various violations of the DBHDS Discharge Protocols and other authorities. After the client was discharged, VOPA used these violations as a platform to obtain needed reforms of the ICF/MR's discharge-related policies, procedures, training programs, and staff supervision practices.

4. **Explain whether pursuing this priority involved collaborative efforts by other entities. If do, describe this collaboration:**

VOPA staff met with representatives from a Tidewater area CSB to discuss availability of community supports and case management services, in support of greater movement to the community from institutions.

5. **If this was addressed through individual advocacy, provide the number of cases handled under this priority** 4

6. **If this priority addresses systemic advocacy or capacity building of the service delivery system for persons with developmental disabilities, please describe how including indicating if any were class actions.**

Virginia plans to build and fully populate a new 75-bed ICF/MR on the current segregated compound of a state-operated ICF/MR instead of in integrated housing with supports provided within the local community. VOPA, representing

the Arc and its members against the State, filed a lawsuit contending that the new institution violates the ADA and Section 504 and is unconstitutional.

**7. Was this priority targeted to under/unserved and minority populations? If so please describe whether or not services to the targeted population resulted in an increase in clients served.**

VOPA contends that residents of state-operated training centers are underserved in the area of disability rights and here their constitutional rights are at risk of being violated.

**8. Describe at least one case summary that demonstrates the impact of the priority.**

VOPA's client, whom the state-operated ICF/MR deemed as severely impaired and incapable of living outside an institution, requested help to obtain a Medicaid Waiver and ICF/MR discharge plan to include a computer and Internet access, a speech device, & appropriate employment to utilize and develop his computer skills. VOPA represented and assisted the client to overcome attempts to avoid providing or deny him post-discharge services he needed or wanted. Our client obtained a Medicaid Waiver slot and discharge and services plans providing for appropriate services including: appropriate placement convenient to his family home, speech and communication technology, computer and internet access at his residence and other locations, and appropriate employment. He was discharged in a timely manner and, despite his placement in a desperately resource-poor area, arrangements were made for him to receive all necessary supports for his success in the community. As part of the client's services plan, he is employed by the CSB performing computerized payroll data entry tasks. He was also referred to DRS for further development of his employable computer skills. He is currently living successfully in the community. While representing this client, VOPA noted various violations of the DBHDS Discharge Protocols and other authorities. After the client was discharged, VOPA used these violations as a platform to obtain needed reforms of the ICF/MR's discharge-related policies, procedures, training programs, and staff supervision practices.

**9. Rounding off to the nearest hundred dollars, how much of this year's grant or award or its program income was spent on this priority? \$50,779**

**10. Will this priority be continued in the next fiscal year? yes**

**1. Priority #3 - - People with Disabilities have Equal Access to Government Services**

**2. Indicator #(2):**

VOPA will advocate for services and supports to enable individuals to remain in the community via systemic advocacy, outreach and training, and analyzing case management services for DD recipients.

**Indicator is:** Partially met

**If “Met or Partially Met” was checked, summarize details, including one or two cases that exemplify the success; for fully met goals, the example case(s) should be successfully closed.**

VOPA conducted small-group presentations on housing and employment rights and numerous one-on-one meetings with residents of twelve (12) assisted living facilities. These were conducted in the Roanoke area, the Eastern Shore, Henrico, East Richmond, and at several rural SW Virginia locations.

VOPA attends the monthly meeting of the Virginians with Mental Disabilities Coalition. This coalition informs policy makers of needs and issues facing individuals with intellectual disabilities living in the community. Although not a formal voting member of the Coalition, VOPA participates as an invited resource for the Coalition.

Case management services is an on-going concern; VOPA is continuing its review of anecdotal information and exploring advocacy and legal strategies to most effectively address the concerns.

**3. List other outcomes realized (if applicable)**

VOPA continues to serve on the Virginia Board for People with Disabilities and as a member of its Community Integration Committee.

VOPA provided training on disability awareness to supervisors and operators at the bus company in Richmond.

VOPA, as part of the DD Network, arranged for a conference with state policy makers and national leaders to develop strategies to leverage and maximize community housing resources.

**8. Describe at least one case summary that demonstrates the impact of the priority.**

Using other funding streams, VOPA successfully closed eleven (11) cases involving discrimination or failure to provide accommodations in public housing. VOPA resolved some cases by providing information on Fair Housing rights, how to request a reasonable accommodation, and how to file a Fair Housing complaint.

**9. Rounding off to the nearest hundred dollars, how much of this year’s grant or award or its program income was spent on this priority? \$13,743**

**10. Will this priority be continued in the next fiscal year? yes**

**1. Priority #4 - - People with Disabilities live in the Most Appropriate Integrated Environment**

**2. Indicator #(1):**

VOPA will advocate for appropriate and timely discharge plans at state mental retardation institutions through case level services that address employment training and planning as a part of discharge plans and by investigating the DMHMRSAS performance contract enforcement with the community services boards.

**Indicator is:** Partially met

**If “Met or Partially Met” was checked, summarize details, including one or two cases that exemplify the success; for fully met goals, the example case(s) should be successfully closed.**

VOPA represented 2 individuals to obtain employment training as part of discharge planning and 5 individuals to obtain MR waiver services. In one case, VOPA’s representation focused on ensuring that the Department of Rehabilitative Services became involved in the client’s planning process and provided appropriate services upon discharge. Through VOPA advocacy, the person was discharged and contact was made with DRS to provide further assistance.

**3. List other outcomes realized (if applicable)**

Not applicable as some work is on-going.

**4. Explain whether pursuing this priority involved collaborative efforts by other entities. If do, describe this collaboration:**

VOPA met with the Department of Rehabilitative Services and proposed that it make regular visits to a state institution and provide residents with information about their rights. VOPA also proposed such an arrangement at a training session of new case counselors.

**5. If this was addressed through individual advocacy, provide the number of cases handled under this priority 6**

**6. If this priority addresses systemic advocacy or capacity building of the service delivery system for persons with developmental disabilities, please describe how including indicating if any were class actions.**

VOPA continues to investigate whether DBHDS is enforcing the terms of the CSB performance contracts, specifically with regard to discharge planning and discharge.

**7. Was this priority targeted to under/unserved and minority populations? If so please describe whether or not services to the targeted population resulted in an increase in clients served.**

VOPA considers residents of state operated ICF/MR to be underserved in the

area of disability rights.

**8. Describe at least one case summary that demonstrates the impact of the priority.**

A client sought VOPA's assistance to obtain discharge from a state operated ICF/MR. VOPA worked primarily with our client's authorized representative in exploring and locating an appropriate placement that our client could visit as a possible permanent community placement. Client is non-verbal and communicates through vocalizations, body movements and facial expressions. Client's authorized representative was provided multiple community resources to explore. She selected the currently under construction, community based ICF-MR that will be operated by the local Community Services Board. VOPA provided information on the MR waiver, residential placement possibilities in the community and Money Follows the Person.

**9. Rounding off to the nearest hundred dollars, how much of this year's grant or award or its program income was spent on this priority? \$41,022**

**10. Will this priority be continued in the next fiscal year? yes**

**1. Priority #4 - - People with Disabilities live in the Most Appropriate Integrated Environment**

**2. Indicator #(2):**

VOPA will promote the use of consumer-driven alternatives to full guardianship through representing individuals for case level services, trainings, and systemic advocacy.

**Indicator is:** Met

**If "Met or Partially Met" was checked, summarize details, including one or two cases that exemplify the success; for fully met goals, the example case(s) should be successfully closed.**

VOPA assisted individuals in drafting an Advance Directive or power of attorney in 5 PADD eligible cases.

**3. List other outcomes realized (if applicable)**

VOPA gave fifteen (15) presentations to parent advocacy and consumer groups across the state.

VOPA serves on the Virginia Public Guardianship Advisory Board (VPGCAB). We carefully tracked a legislative proposal dealing with the issues of multiple jurisdiction and interstate transfer of guardianship. VOPA presented models of person-centered planning to the VPGCAB subcommittees on Planning and Development and on Substitute Decision Making and the Board asked for a formal training on person-centered planning at the fall training conference for all

public guardians. The Board also tasked the Planning and Development subcommittee to read the draft program guidelines with an eye toward principles of person-centered planning. This is a new and exciting concept for many members of the Board, and its inclusion as best practices for the public guardianship program has the potential for a huge systemic impact.

**8. Describe at least one case summary that demonstrates the impact of the priority.**

VOPA's client recently turned 18, and her parents were investigating the possibility of guardianship. She and her parents attended a VOPA presentation on alternatives to guardianship. VOPA gave her and her parents information about alternatives to guardianship and assistance in writing an advance directive. VOPA drafted a health care Power of Attorney and guardianship was avoided.

VOPA assisted another client to draft an advance directive for health care. At the time her mother contacted VOPA, she had already spoken to an attorney about petitioning for guardianship, but they both wanted to avoid that, if possible. Guardianship was avoided due to VOPA's involvement.

**9. Rounding off to the nearest hundred dollars, how much of this year's grant or award or its program income was spent on this priority? \$24,256**

**10. Will this priority be continued in the next fiscal year? yes**

**1. Priority #5 - - People with Disabilities are Employed to their Maximum Potential**

**2. Indicator #(1):**

VOPA will promote increased vocational training for MR institution residents by representing 10 individuals.

**Indicator is:** Partially Met

**If "Met or Partially Met" was checked, summarize details, including one or two cases that exemplify the success; for fully met goals, the example case(s) should be successfully closed.**

VOPA represented 3 residents of state-operated ICFs/MR in order to obtain enhanced vocational training opportunities.

**3. List other outcomes realized (if applicable)**

VOPA reviews the annual Medicaid survey of each of the five state operated ICFs/MR in order to identify issues relating to vocational training.

**4. Explain whether pursuing this priority involved collaborative efforts by other entities. If do, describe this collaboration:**

VOPA collaborated with facility staff, community services boards, and the Department of Rehabilitative Services in order to develop appropriate vocational

or prevocational plans for residents.

**5. If this was addressed through individual advocacy, provide the number of cases handled under this priority 3**

**6. If this priority addresses systemic advocacy or capacity building of the service delivery system for persons with developmental disabilities, please describe how including indicating if any were class actions.**

VOPA aggressively advocates for the inclusion of vocational training in the IHP of each resident for whom such training is appropriate and as an essential component of discharge planning.

**7. Was this priority targeted to under/unserved and minority populations? If so please describe whether or not services to the targeted population resulted in an increase in clients served.**

VOPA considers residents of state operated ICF/MR to be underserved in the area of disability rights.

**8. Describe at least one case summary that demonstrates the impact of the priority.**

VOPA's client requested VOPA's help to obtain modifications to a hearing aid so he could wear the device during all waking hours. VOPA reported the problem to the state-operated ICF/MR director. Later, when the problem was not remedied, VOPA worked with the head of Speech Therapy to help our client obtain a usable and effective hearing aid. This improved his communication with family members, staff, and others. It increased his safety in work and off campus environments, increased his ability to benefit from work and other training programs, and facilitated social interactions and relationship development with family, peers and staff.

**9. Rounding off to the nearest hundred dollars, how much of this year's grant or award or its program income was spent on this priority? \$7146**

**10. Will this priority be continued in the next fiscal year? yes**

**1. Priority #6 - - People with Disabilities have Equal Access to Appropriate and Necessary Health Care**

**2. Indicator #(1):**

VOPA will investigate allegations of inadequate medical care for 5 residents, conduct 2 investigations, and review barriers to receiving dental coverage under Medicaid.

**Indicator is:** Partially met

**If "Met or Partially Met" was checked, summarize details, including one or**

**two cases that exemplify the success; for fully met goals, the example case(s) should be successfully closed.**

VOPA is conducting 3 investigations into allegations of inappropriate medical care of residents of ICFs/MR. All 3 are still on-going.

VOPA is investigating three (3) incidents of death due to choking incidents at state-operated ICFs/MR. One investigative report will be published soon.

**3. List other outcomes realized (if applicable)**

VOPA reviews the annual Medicaid survey of each of the five state operated and 30 locally or privately run ICFs/MR in order to identify issues relating to the provision of medical care.

**4. Explain whether pursuing this priority involved collaborative efforts by other entities. If do, describe this collaboration:**

Not applicable

**5. If this was addressed through individual advocacy, provide the number of cases handled under this priority 6**

**6. If this priority addresses systemic advocacy or capacity building of the service delivery system for persons with developmental disabilities, please describe how including indicating if any were class actions.**

VOPA continues to advocate for the provision of timely and appropriate medical care in the community and actively seeks opportunities to educate care providers concerning the needs of individuals with disabilities.

**7. Was this priority targeted to under/unserved and minority populations? If so please describe whether or not services to the targeted population resulted in an increase in clients served.**

VOPA considers residents of state-operated ICF/MR to be underserved in the area of disability rights.

**8. Describe at least one case summary that demonstrates the impact of the priority.**

Our client was found choking on an unknown item requiring the use of the Heimlich Maneuver to clear her airway. The item was a tortilla chip even though she requires a pureed diet. The investigation conducted by the ICF/MR concluded that a staff brought tortilla chips and shared them with the residents. Our client was able to obtain a chip and tried to eat it. Despite that our client requires a pureed diet and has an Eating Precaution Plan, the internal investigation concluded that staff was not negligent in allowing Client to have access to tortilla chips. All staff were retrained on Client's Eating Precaution Plan. VOPA continues to monitor the implementation of eating precaution plans through regularly scheduled monitoring to include mealtime observation.

9. **Rounding off to the nearest hundred dollars, how much of this year's grant or award or its program income was spent on this priority? \$6497**

10. **Will this priority be continued in the next fiscal year? yes**

1. **Priority #6 - - People with Disabilities have Equal Access to Appropriate and Necessary Health Care**

2. **Indicator #(2):**

VOPA will represent five children who have been denied Medicaid services under the Early and Periodic Screening Diagnosis and Treatment Program and provide trainings.

**Indicator is:** Partially met.

**If "Met or Partially Met" was checked, summarize details, including one or two cases that exemplify the success; for fully met goals, the example case(s) should be successfully closed.**

VOPA provided training on EPSDT to six (6) groups of over twenty (20) people. VOPA represented two children to advocate for them to receive appropriate services under the EPSDT program. In one case, VOPA secured an adapted exercise bicycle for a child with a severe spinal cord injury. In another case, VOPA secured a device to help a child stand up on her own. In all cases, VOPA provides clients with assistance in drafting and submitting Letters of Medical Necessity and advocates for the services to be approved.

3. **List other outcomes realized (if applicable)**

After each training, VOPA staff spend time with the attendees answering questions and providing additional information and referral.

8. **Describe at least one case summary that demonstrates the impact of the priority.**

A parent attended VOPA's training on EPSDT and requested VOPA's assistance getting nutritional supplements. VOPA wrote a letter to the parent, with information about EPSDT, information about letters of medical necessity (including examples) and information about supplements and how they can be covered under EPSDT. VOPA provided the parent with technical assistance on next steps.

9. **Rounding off to the nearest hundred dollars, how much of this year's grant or award or its program income was spent on this priority? \$8314**

10. **Will this priority be continued in the next fiscal year? yes**

1. **Priority #6 - - People with Disabilities have Equal Access to Appropriate and**

## **Necessary Health Care**

### **2. Indicator #(3):**

VOPA will represent five persons with disabilities who have been denied Medicaid waiver services, provide systemic advocacy, conduct monitoring and provide training.

**Indicator is:** Met

**If “Met or Partially Met” was checked, summarize details, including one or two cases that exemplify the success; for fully met goals, the example case(s) should be successfully closed.**

VOPA developed a presentation on available services under the Medicaid Waivers and presented to five (5) parent and provider groups across the state reaching about 90 people. Systemic advocacy was started and continues into FY2010 and VOPA served 6 individuals.

### **3. List other outcomes realized (if applicable)**

VOPA developed a quality assurance checklist for Medicaid Waiver group homes and requested inspection reports from DBHDS. From these reports, VOPA selected two (2) group homes in Suffolk and three (3) group homes in Waverly for follow-up surveys by VOPA staff. VOPA found multiple areas that the previous inspections did not address that impact the safety and quality of services to the residents. During the next phase, we will contact DBHDS in December 2009 to follow up on completion of their annual site visit inspections to these locations and recommend any corrective actions regarding the DBHDS licensure inspection process.

### **8. Describe at least one case summary that demonstrates the impact of the priority.**

VOPA represented 6 individuals. One client had a significant amount of lag time between the approval of reinitializing Personal Assistance and Respite waiver services and being discharged from the state-operated ICF/MR. VOPA advocated with Medicaid and within two weeks had approval and both services were reinstated. Without these services, the individual was at risk of re-institutionalization.

### **9. Rounding off to the nearest hundred dollars, how much of this year’s grant or award or its program income was spent on this priority? \$25,561**

### **10. Will this priority be continued in the next fiscal year? yes**

## Section 7: Developmental Disabilities Network Collaboration

- A. Provide information related to only those issues/barriers affecting individuals with developmental disabilities and their families in your State that the DDC, P&A, and UAP(s) (the DD network) have jointly identified as critical State issues/barriers.**

**Using short titles, list 5-10 areas that the DDC, P&A, and UAP(s) have identified as critical State issues/barriers. Then, by checking the circle(s) to the left of the short titles(s), identify any issues/barriers selected by your State DD Network for joint collaboration.**

1. Policy Maker Education
2. Increase in ICFs/MR and plan for rebuilding state institutions
3. Reduction in Medicaid Waivers waiting lists
4. Lack of integrated developmental disabilities service delivery system
5. Abuse and Neglect
6. Outreach
7. Funding opportunities
8. Children in nursing homes and institutional settings
9. Advances and opportunities for Self Advocacy

- B. Provide the following information for at least one of the issues/barriers selected for DD Network collaboration. Repeat this section for reporting each issue/barrier selected for DD Network collaboration.**

- 1. Issue/Barrier # (from above):**

1

- 2. Provide a brief description of the collaborative issue/barrier and expected outcome(s).**

The DD Council (Virginia Board for People with Disabilities, VBPD) and the P&A (VOPA) regularly collaborate during Virginia's General Assembly regarding proposed legislation and budget issues that may impact people with disabilities. The University Center of Excellence (Partnership for People with Disabilities) is also consulted. This collaboration facilitates educating policymakers about opportunities to advance the rights of persons with disabilities as well as identifying policies and proposed legislation that pose risks to persons with disabilities. The DD partners worked with the Arc of Virginia to educate legislators

- 3. Reference applicable SGP Goals:**

This applies to all goals, but Goals 2,3, and 4 in particular.

**4. Describe the P&A's specific roles and responsibilities in this collaborative effort.**

VOPA has a representative at the VBPD quarterly meetings and at the Advisory Council for the Partnership for People with Disabilities. The DD Network routinely collaborates on issues before the General Assembly. During the 2009 session, the Network and The Arc actively promoted information supporting legislative and budgetary reforms supporting full community integration. The DD network and the Arc also educated the DBHDS on the need to fully leverage housing funds to ensure greater community access for people with developmental disabilities. VOPA met with policy makers, drafted position papers and testified at legislative hearings.

**5. Briefly identify problems, if any, encountered as a result of this collaboration.**

None known

**6. Describe unexpected benefits, if any, of this collaborative effort:**

Although not entirely unexpected, the collaboration seemed to enhance the credibility of both VOPA and VBPD as reliable and trusted providers of information. Each gained a broader perspective on the issues based on the information and experience of the other.

**7. If your P&A can provide technical assistance expertise in this area to other States, please describe.**

**8. If any, describe the technical assistance needs the P&A/DD Network have in this area.**

**1. Issue/Barrier # (from above):**

2

**2. Provide a brief description of the collaborative issue/barrier and expected outcome(s).**

The DD Council (Virginia Board for People with Disabilities, VBPD) The University Center of Excellence (Partnership for People with Disabilities), the Arc of Virginia and the P&A (VOPA) regularly collaborate during Virginia's General Assembly addressing proposed legislation and budget issues that may impact people with disabilities. Virginia's unlawful policy, legislation and budget activities intending to re-build state operated institutions for people with intellectual disabilities spurred the development of the Alliance for Community. This Alliance strove to educate advocates, family members and residents about investing in community based services instead of building buildings. Individuals at the institutions need quality services and not new buildings. Truly individualized person-centered service plans can more easily be developed and implemented in smaller settings that are integrated into the

same communities that people without intellectual disabilities live in and at a greater economical savings.

**3. Reference applicable SGP Goals:**

This applies to all goals, but to goals 3 and 4 in particular.

**4. Describe the P&A's specific roles and responsibilities in this collaborative effort.**

As the P&A, VOPA took the lead with identifying specifically what laws and regulations the proposed actions were going to violate. VOPA educated many legislators and staff about the ADA, the DD Act and the Virginians with Disabilities Act. VOPA collaborated with the other Alliance members to develop talking points for advocacy efforts.

**5. Briefly identify problems, if any, encountered as a result of this collaboration.**

None known

**6. Describe unexpected benefits, if any, of this collaborative effort:**

The Alliance developed issue papers that were publicized. Nearly 100 organizations and individuals signed on to the papers demonstrating the pervasiveness of rejection of continuing to unnecessarily and unlawfully institutionalize individuals with DD.

**7. If your P&A can provide technical assistance expertise in this area to other States, please describe.**

**8. If any, describe the technical assistance needs the P&A/DD Network have in this area.**

## Section 8: Coordination

Check if the following programs are housed in the same organization as the P&A program:

- ✓ **Client Assistance Program (CAP)**  
**Long Term Care Ombudsman (Older Americans Act)**
- ✓ **Other:**

**If other, please list:**

Protection and Advocacy for Individuals with Mental Illness,  
Protection and Advocacy for Individual Rights,  
Protection and Advocacy for Beneficiaries of Social Security,  
Protection and Advocacy for Assistive Technology,  
Protection and Advocacy for Traumatic Brain Injuries,  
Protection and Advocacy for the Help America Vote Act, and  
State funding to support Virginians with Disabilities Act activities

**If the Client Assistance Program (CAP) and the Long Term Care Ombudsman (Older Americans Act) are not part of the P&A System (PADD, PAIMI, PAIR AND PAAT programs) describe coordination between the PADD program and the CAP and the Long Term Care Ombudsman (Older Americans Act.)**

Coordination with the State Long-Term Care Program is particularly important during the legislative session. VOPA presented at their annual conference about strategies to recognize and foster mutual efforts to decrease abuse and neglect. The Long Term Care Ombudsman provided a training for VOPA staff about the advocacy efforts and challenges they face. VOPA received referrals and reports of incidents from the Long Term Care Ombudsman staff and made referrals to the Ombudsman when appropriate.

The Department of Medical Assistance Services (DMAS) is the primary source of funding for the long-term care system in Virginia. Again, VOPA coordinates with them on an as needed basis.

**Describe your system's relations with agencies other than above and any inter-agency agreements or joint projects you may have, other than mentioned above.** VOPA collaborates with other state-wide advocacy entities and disabilities service providers as needed.

### **Section VIII. Services Provided Using Non-Part C Funding**

**Are services and activities benefiting persons with developmental disabilities and their families supported by funding other than that provided by Part C of the DD Act or its program income.**

No

**Please describe the projects funded with non-part C funding or its program income.**

None

### **Section 9: Comments and Clarification**

In December 2008, the Governor unexpectedly announced the closure of a state operated ICF/MR as a cost-saving measure. Out of concern for immediate jeopardy of residents at that facility, VOPA dramatically increased our presence, monitoring for potential abuse and neglect on weekends, holidays and evening in addition to regular workday visits. Virtually all VOPA staff were involved in this intensive monitoring effort for approximately two months following the announcement. Unfortunately, on receipt of ARRA funds, the legislators reversed the decision to close the facility. Nonetheless, a multidisciplinary team of VOPA staff is continuing to work to assist individual residents attempting to leave the ICF/MR.

VOPA served an additional 67 PADD eligible individuals whose cases were carried forward from previous years. VOPA also provided short-term assistance services to another 16 individuals whose requests for services did not fall within FY09 objectives.

VOPA participated on a national advisory group for HRSA about cultural competency and serving people with TBI. We had hoped to generalize lessons learned here to our Office's operations in general. However, the HRSA vendor facilitating the work group lost the contract and the new vendor has not yet followed up on this initiative.

VOPA is seeking access to peer review records to which it is entitled under federal law. VOPA initially sought the records as part of investigations it was conducting into instances of death and serious injury at two state-operated institutions. The defendants refused to provide the records and VOPA sought judicial relief. The case is currently pending a decision on VOPA's petition for a writ of certiorari with the U.S. Supreme Court.

VOPA's Operations Coordinator left the organization in the spring of FY09 after an extended leave. During the absence and subsequent vacancy, VOPA continued to assess and re-organize the administrative functions within the Office. The vacancy was not planned and the position had been held by a long-time State employee. Her departure left a gap in institutional knowledge of state functions and contacts. However, the administrative staff in place seized this opportunity to quickly learn new skills and take on new responsibilities. Within 6 months of the resignation, we had all of the

position's responsibilities covered or planned for. In addition, we are anticipating the retirement of the VOPA Fiscal Officer in FY2010 which will also lend itself to challenges and opportunities for the administrative staff.

VOPA does a comprehensive and systemic review of all Critical Incidents at state operated ICFs/MR. (In FY09, we received 426 CIRs from state operated ICFs/MR.) VOPA does a similar systemic review of all reports forwarded by Adult Protective Services (APS). We read hundreds of reports and enter information into databases. We discuss in detail all CIRs that involve injuries within current program priorities and other alarming or unusual reports. In addition, the VOPA Executive Director conducts a weekly meeting to address the reports, their implications, and remedial action. Staff assigned to specific facilities receive copies of each of the reports from the facilities they are monitoring. This is an additional tool for monitoring, investigating and identifying patterns of injuries and practices. We conduct quarterly trend analyses to identify systemic patterns across all facilities and within each facility. Between the data and VOPA's knowledge of and experience with the facilities, troubling or suspicious injuries are further explored in a variety of ways. It should be noted that VOPA concludes that although these incident reportings are required either by statute or policy, they are not reflective of all incidents of abuse or neglect. Much abuse and neglect does not meet the legal reporting definitions. VOPA suspects the reports we do receive are just a fraction of the injuries and abuse and neglect that occurs within these facilities.

The Virginia Office for Protection and Advocacy (VOPA) has made a deliberate decision to take cases that we believe will have a strong systemic impact on the lives of Virginians with disabilities. Although we opened a targeted number of individual cases, we believe that by tying them directly to systemic reform, we are making a significant impact on a much larger population group.

VOPA plans its objectives based on the needs within the state; not by funding stream or specific disabilities. Some of the identified estimated cases and proposed activities may have been addressed in conjunction with other funding streams, but the result is still a positive impact on PADD-eligible individuals.