JOINT LEGISLATIVE AUDIT & REVIEW COMMISSION

THE VIRGINIA GENERAL ASSEMBLY

PROGRAM EVALUATION

VOCATIONAL REHABILITATION IN VIRGINIA

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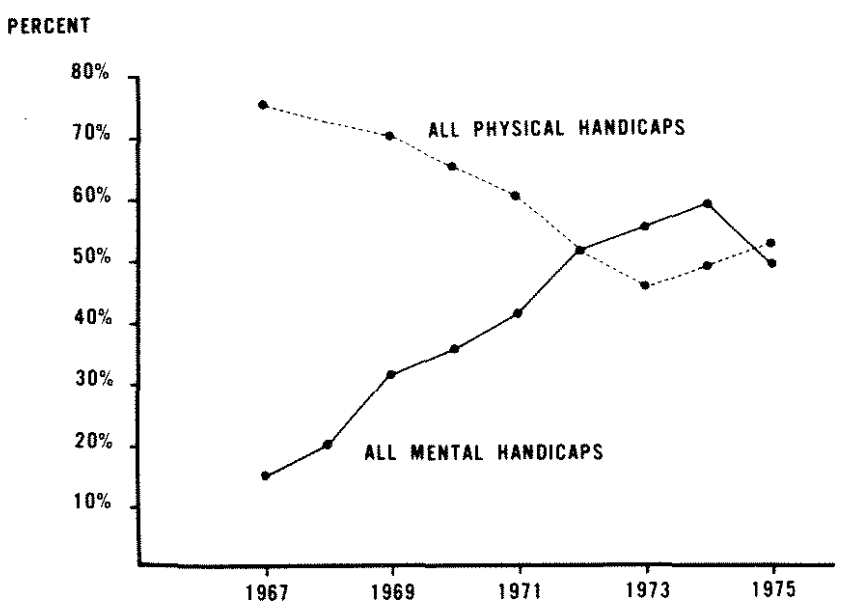
SUMMARY

VOCATIONAL REHABILITATION PROGRAMS

Physical and mental handicaps can prevent many people from leading full and productive lives. Through vocational rehabilitation, an attempt is made to help individuals overcome their handicaps and become employed. Two State agencies administer the rehabilitation program--the Department of Vocational Rehabilitation (DVR) and the Commission for the Visually Handicapped (VCVH). Virginia has had a vocational rehabilitation program since 1920 when federal grants were first made available to assist crippled war veterans. And, even though program eligibility has been expanded to a wide range of clientele, a primary objective has always been to help the disabled become employed. Each agency has a comprehensive service delivery system that can provide a client with many kinds of services including physical restoration, training, counseling, and job placement. Counselors spend over $12 million annually for client services. These services are obtained through a wide variety of public and private sources that include the Woodrow Wilson Rehabilitation Center, colleges, physicians, sheltered workshops, hospitals, and clinics.

Program growth was slow until 1965 when federal legislation broadened eligibility criteria and increased financial participation, enabling the programs to serve more people than ever before. At that time, the rehabilitation process was thought to be so successful in dealing with traditional physical disabilities that it was expanded to include many cultural, social, and mental handicaps. Thus, in 1975, the Department of Vocational Rehabilitation dealt with more than 34,000 individual referrals of which over 15,500 persons were found eligible for service and 9,139 were successfully rehabilitated. During this time period, the composition of client disabilities served shifted from an emphasis on physical handicaps to a fairly even distribution between mental and physical handicaps as shown in the following illustration.

DISABILITIES OF CLIENTS REHABILITATED--1967-1975



Vocational handicaps may involve such diverse physical conditions as paraplegia, amputation, hernias, and allergies, or mental conditions such as psychosis, drug addiction, mental retardation, and various emotional disorders. Federal financial support has increased from 50% of total program costs in 1920 to 80% in 1975 while several projects are solely funded by federal grants. In FY 1975, Virginia received $20,925,798 in federal funds for vocational rehabilitation programs. State appropriations totaled $4,243,615.

The legislative goals for vocational rehabilitation rely heavily on federal law and regulation. The primary program purpose is to provide clients with services that will realistically enhance their employment potential. These services are supposed to be sufficiently comprehensive to ensure the client's rehabilitation. Regulations state that if all eligible clients cannot be served, agencies should establish an order of selection process so that the severely disabled will be served first. Finally, rehabilitants should generally be capable of maintaining a competitive wage-paying job in order to become or remain independent and reduce dependence on family, charity, or the State for economic support. As Virginia's rehabilitation programs have grown, the development of an order of client selection has essentially been a matter of agency choice or federal mandate.

Although DVR has helped many people overcome handicaps and enter the labor market, the department's rapid growth has placed severe demands on its service delivery and management systems. Many previous reviews, federal and State, found the department had not adequately responded to those demands. The U. S. Department of Health, Education, and Welfare and the Rehabilitation Services Administration both recommended greater attention be given to eligibility standards and management controls. A State Police investigation in 1974 found several instances of illegal spending by some counselors, and the Auditor of Public Accounts reported there were poor financial controls over expenditures. The DVR Board carried out an internal review in 1974 and concluded that management improvements were needed and there was inordinate pressure on counselors to close a large volume of cases also as successfully rehabilitated.

This review, while synthesizing and merging the information contained in prior reports, also concludes there are a number of management and program weaknesses that require prompt attention and can be corrected at little additional cost to the State. Furthermore, some of the original data gathered for this evaluation offers a view of the impact rehabilitation efforts have had over time--an evaluation never reported earlier. Three of the evaluation methods used by JLARC are especially important. First, field interviews were held with half of the 250 field counselors and with 28 of the 38 supervisors. Counselor comments were especially useful to give substance to the voluminous statistics generated by the department. Second, a random sample of 120 case files of clients successfully rehabilitated in FY 1975 was surveyed to assess service delivery. The cases are used to illustrate findings where possible. Finally, an extensive wage and employment follow-up survey was made to determine the long term outcome of the rehabilitation program.

REHABILITATION MANAGEMENT

DVR employs 1,500 people and spends more than $27 million annually. Improved efficiency and effectiveness in using these resources for vocational rehabilitation depends on changes being made in the following areas:

- A comprehensive priority system that builds on the federal mandate to serve the severely disabled and develops an order of client selection based on specific public goals and objectives needs to be developed;

- Financial administration, planning, and controls at the counselor level need improvement;

- Middle level managers and regional directors need more authority delegated to them; and

- There must be less emphasis on production quotas based on the quantity of rehabilitation and more concern with the quality of each rehabilitation measured by performance criteria which recognizes effort and quality of service.

Priority Selection (pp. 85-89)

It is not possible for DVR to serve all eligible Virginians with available resources. The estimated eligible population--105,000--exceeds the agency's service capability. The number of persons added to the handicapped population through disease or accident each year exceeds the number successfully rehabilitated. In its most productive year (1974), the agency rehabilitated 13,600 persons while another 15,000 became disabled. This shortfall in service capacity emphasizes the need for sound selection priorities and careful management.

A system of priorities in client selection has been acknowledged by DVR since 1966. At first, the selection process was based on cost-effectiveness considerations; but, federal selection criteria have been changed to depend on the type of disability. Federal legislation now mandates an emphasis on the severely disabled; however, at present, less than half of all persons served fall into a federal or State priority group. Often, State identified priorities simply duplicate the federal priority of the severely disabled. Most importantly, counselors have not used, on a daily basis, a selection statement, budget, or other procedure which reflects specific service priorities.

DVR needs to develop a system of priorities based on factors beyond the disability-based priority system. Selection should address specific public goals the agency intends to achieve and should include consideration of:

- the cost of rehabilitation in terms of reasonableness;

- the opportunity to contribute to a reduction or elimination of public assistance;

- the extent to which specific public services are available that can be used in combination with DVR services to deal with long term or multiple disabilities;

- the extent to which similar benefits are available to finance rehabilitation; and

- the demonstrated program impact after rehabilitation on certain client groups in employment and income.

Also, formalized procedures are needed to implement and control priorities through budgets and expenditures. Finally, the system must be clearly understood by all levels of management and communicated to counselors who are responsible for applying agency priorities in day-to-day operations. To ensure full participation in developing the Commonwealth's vocational rehabilitation program direction, DVR should provide the General Assembly with the opportunity to comment, review, and concur in the program objectives.

Financial Controls (pp. 91-98)

The adequacy of internal financial controls and planning has been a basic problem for DVR for some time. A Grand Jury investigation in December, 1974, found that funds intended for clients had been used illegally. By November, 1975, DVR had encumbered or spent nearly all of its case service funds even though half the fiscal year remained. As a result, a moratorium was placed on spending through March, 1976, and clients were denied new or additional services.

Although some of the financial problems were caused by factors beyond DVR control, lack of internal budget procedures aggravated the situation. In the past, there had been little concern for budget planning since funds were readily available. If a counselor's expenditures exceeded the budget, it could be easily made up by a transfer from another counselor. Supervisors requested funds based solely on previous expenditure patterns, and approved budget figures generally were not known until after the fiscal year had begun and some financial commitments already made. There were few agency controls and no standardization of counselor budgets. Some supervisors used self-designed control instruments while others used none. Supervisors also relied on transfers between field offices to make up overspending by their counselors.

DVR needs to improve its financial planning and control procedures to ensure expenditures are consistent with agency plans and objectives. As a minimum, budgets for each field office and counselor must be set with overspending and transfers strictly monitored. The department could benefit from extending the quarterly allotment process used at the State level to field offices.

Delegation of Authority (pp. 93-94)

Closely related to the need for improved financial controls is the requirement to delegate more authority to middle level managers. The Board of Vocational Rehabilitation adopted an organizational structure in January, 1972, which divided the State into four regions, each headed by a director. The regional directors have not been delegated sufficient authority to carry out their responsibilities. For example, the role of the regional director, in the crucial area of monitoring and evaluating regional activities, is to record the findings and report to the DVR central administrative office. Many management problems might be averted if a regional director and subordinate supervisors had the necessary authority to act on specific regional financial and program needs.

A principal responsibility of DVR supervisors is to audit case files. This activity includes detailed technical reviews to ensure compliance with federal requirements. The quality and usefulness of case audits would be substantially upgraded if supervisors would judge program eligibility, effectiveness of the case plan, appropriateness of services provided, and the extent to which the client benefited from DVR services.

Measures of Productivity (pp. 107-110)

DVR relies on the number of successful rehabilitations as the principal measure of counselor productivity without a concurrent measure for quality of service or the type of client involved. This measurement system prevents the department from adequately evaluating counselor performance or allocating resources to those programs which best serve agency priorities. Instead, the lack of a comprehensive productivity measure results in pressure on counselors to accept and rehabilitate the clients who represent the easiest cases in order to meet quotas.

The need for objective performance standards is basic to rehabilitation management and evaluation. However, DVR does not use productivity measures which can identify one type of rehabilitation from another. Thus, there is no way to determine if individual priorities and program goals are being met. Characteristics which include quality of service should be considered when judging each rehabilitation; and, a counselor productivity reporting system needs to incorporate factors such as severity of the disability, type of disability served, and the proportion of severely disabled that are rehabilitated.

PROGRAM ELIGIBILITY

The emphasis on rehabilitating large numbers of clients has resulted in providing services to many persons with mild or minimal disabilities--a matter of special concern to HEW since passage of the 1973 Rehabilitation Act. The Act requires that state rehabilitation agencies emphasize service to clients with the most severe disabilities. The eligibility determination process is to be used to screen clients so that individuals most in need of service are identified. The eligibility decision is based on each prospective client meeting three criteria:

(1) A medical professional must diagnose a disability;

(2) In the counselor's judgement, the disability must constitute a substantial handicap to employment; and

(3) There must be a reasonable expectation, in the counselor's opinion, that rehabilitation services will benefit the individual's employability.

DVR has been criticized in HEW audits for providing services to ineligible persons, for inadequately documenting the eligibility decisions made by counselors, and for providing service to many persons who, while technically eligible, are only minimally disabled. The basis for many of these criticisms still exists.

Minimal Handicaps (pp. 19-22)

The majority of DVR clients are generally not handicapped by a severe disability. Most physical and mental disabilities are in categories identified by federal agencies as a minimal handicap and include personality disorders, mild retardation, mental illness, alcoholism, drug addiction, or a general medical condition such as an ulcer, hernia, or allergy. In July, 1975, for example, the Rehabilitation Services Administration expressed concern about seven specific disability categories which it considered to be characterized by minimal handicaps. Based on an analysis of 1973 data, over half of DVR's clients had been found to be in one of these seven categories, and Virginia ranked third nationally in the proportion of clients rehabilitated with minimal disabilities. By 1975, the proportion had fallen to 42%, but this figure still represents a high concentration of service for minimal handicaps.

Case File Documentation (pp. 22-24)

An audit of DVR conducted in 1974 by RSA found that ten percent of the clients served were ineligible. The largest group judged to be ineligible consisted of persons whose employment handicap was not adequately explained. During the course of this review, the JLARC staff also found that DVR counselors do not fully document the reasons for accepting a client. Poor documentation clearly hinders departmental efforts to reduce the number of minimally handicapped cases accepted. DVR should strengthen its internal audit capability by emphasizing the need for adequate review of case work documentation. Specific information is required regarding why a diagnosed medical or psychological condition is a handicap to employment and counselors should make greater use of diagnostic reports in planning vocational goals.

The Severely Disabled (pp. 28-32)

The severely disabled are a key client group that require priority emphasis. DVR is giving greater attention to serving this group; however, several improvements are needed. Foremost among these is the development of specialized job development and placement techniques. DVR should consider assigning some of the personnel that will become available through planned elimination of specialized corrections and drug programs to jobs involved in placement of the severely disabled.

While DVR does now assign priority to clients with severe disabilities, it lagged far behind most other states in serving this type of client when the 1973 Rehabilitation Act was implemented. In 1975, severely disabled rehabilitants in Virginia made up only 24% of all successful rehabilitants compared with 34% nationally--only six states reported a lower proportion of severely disabled rehabilitants.

Financial Eligibility (pp. 42-44)

Most other state vocational rehabilitation agencies use a financial needs test to determine whether a client should pay for a portion of rehabilitation costs. Need is usually based on a reduction of income and assets by

certain standard exemptions. Generally, individual income in excess of some maximum standard is considered to be available to help finance the rehabilitation. JLARC found that the financial needs test used by DVR should be reconsidered. In addition to the standard exemption formula, DVR clients may also use an itemized calculation method. Under this method, common expenses such as rent, food, and most other legally incurred debts can also be used to reduce available income. Since there is no limit on the amount of income that can be exempted, relatively affluent clients may receive rehabilitation services at full public expense.

DVR should design a financial needs test that can be applied uniformly. If the standard exemptions are too low, they should be adjusted upward. Local supervisors and regional directors could be authorized to waive the financial standards on a case-by-case basis to allow for unusual circumstances.

An improved method of documentation of client income would serve two useful purposes. First, documentation decreases the chance of misrepresentation of client financial assets. Secondly, documentation such as a state tax return or a federal form 1040 would provide valuable information in assessing client income growth. Information regarding earnings, before and after rehabilitation, is essential as an accurate assessment of programs costs and benefits. At present, DVR does not verify client income or assets as part of its financial needs test. The absence of such documentation reduces the likelihood of determining fraud and increases potential for abuse.

SERVICE DELIVERY

The rehabilitation client can receive a wide range of services including medical and psychiatric care, surgery and hospitalization, vocational or adjustment training, maintenance, and job placement. In fact, the vocational rehabilitation service options are greater than those available to any other human service delivery agency in the State. However, DVR has not provided for adequate case planning and management which often limits effective and appropriate service delivery.

Case Planning (pp. 39-42)

A key factor in providing appropriate client services is establishment of a realistic client plan. This critical function is intended to identify the specific services to be provided and who is to pay for them. The principal planning tool available to counselors is an Individualized Written Rehabilitation Program (IWRP) which describes the logical progression of events from identifying the vocational goal through job placement. The IWRP specifies responsibility of both counselor and client in some detail. The IWRP is still relatively new to DVR, and was not fully implemented until December, 1975. Every case examined during this review had either an IWRP or the previous planning document; and, several shortcomings were found that prevent case planning from reaching its full potential. For example, in one out of every six case files reviewed the plans:

- specified an unrealistic vocational objective,
- were back-dated,
- called for unnecessary services, or
- were incomplete.

These deficiencies indicate that supervisors are not performing careful reviews and often overlook many of the substantive shortcomings of a plan. Of particular concern in the case files reviewed were seven plans with unrealistic vocational objectives and twelve plans which were prepared after the client had a job. The former defect can easily result in an unsuccessful rehabilitation effort--the latter is clearly inappropriate.

Rehabilitation Costs (pp. 46-52)

The average case service cost to DVR for a successful rehabilitation in 1975 was $758. There was a wide range in expenditures with 22 cases costing in excess of $10,000. Although case costs may vary depending on the disability, there is no clear relationship between the severity of the disability and case service costs. The assumption that a severely disabled client is more expensive to rehabilitate than other clients has been a central aspect of DVR's budget presentations. However, a cost analysis showed that four of the ten disabilities most costly to rehabilitate are not routinely regarded as severely disabled. Almost half of the clients in the ten most expensive disability categories were probably not severely disabled. Moreover, the mentally ill, accounting for over one-fourth of all severely disabled rehabilitants, are relatively inexpensive to rehabilitate. The average rehabilitation cost for a mentally ill client is $436.

The key element in determining cost is the type of service provided rather than the severity of the disability. Specifically, if vocational training is provided, the case will generally involve high costs since supportive services such as maintenance and transportation, as well as tuition and fees, are involved. DVR acknowledged the high cost of vocational training when it limited payment for college tuition to only the severely disabled as a cost control measure in FY 1976. (Training costs, particularly the prepayment of college tuition in September, contributed heavily to the commitment of almost all case service monies early in FY 1976.) Many of the DVR clients with nonsevere disabilities such as hay fever, allergies, personality disorders, or drug addiction are provided college or other vocational training. This represents a major investment for the department. DVR needs to consider screening each client during the planning process to determine if the cost is justified in relation to developed priorities. In addition, supervisors should routinely review high-cost training plans.

Service Delivery (pp. 53-61)

DVR clients may receive any one of 14 different services including:

- evaluation
- counseling and guidance
- physical and mental restoration
- vocational and other training

- maintenance and transportation
- services to members of the client's family
- interpreter services for the deaf
- special services for the blind
- telecommunication, sensory, and other technological aids and devices
- recruitment and training for public service employment
- placement in suitable employment
- post-employment services
- occupational licenses, tools, equipment, initial stocks, and supplies
- other goods and services which can reasonably be expected to benefit a handicapped individual in terms of employability

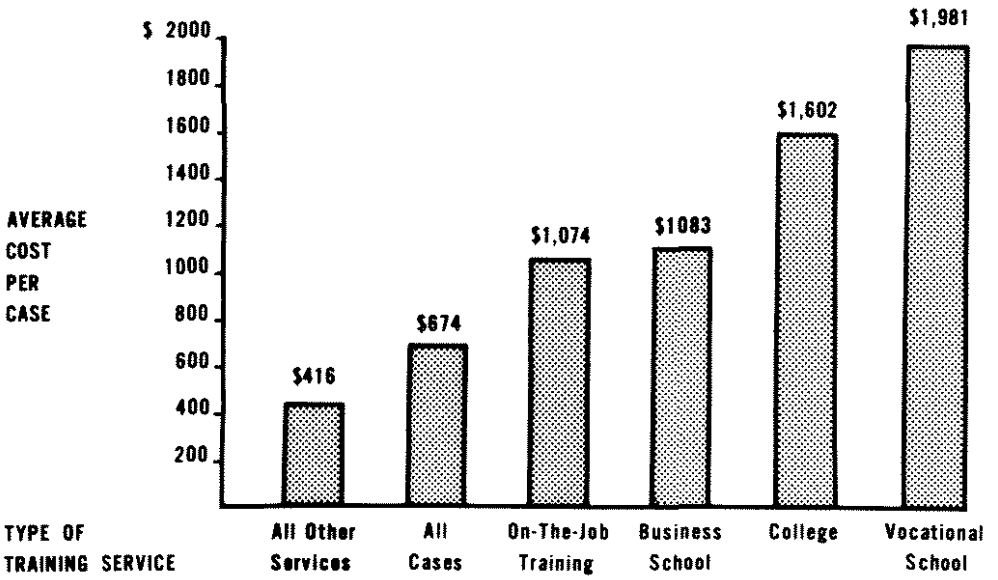
Counselors have great latitude in the range of services offered a client. They may authorize payment for such items as shoes, fuel oil, customized vehicles, surgery, psychiatric care, prothesis, college tuition, workshop per diem, and on-the-job (OJT) training. The two principal services provided are restoration and training. These service options have distinct patterns since clients with physical disabilities tend to receive restoration services while those with mental or emotional disabilities tend to receive training.

Physical Restoration. Over 3,000 persons received surgical or medical services and were successfully rehabilitated in 1975. These clients were generally not classified as severely disabled but required either treatment for conditions such as nonmalignant tumors, digestive disorders, and dental problems, or payment for hearing aids, eye glasses, special shoes, and other appliances. Clients who receive only restoration service generally have low incomes and no health insurance, but are not qualified for Medicaid. This type of client generally requires little special effort to rehabilitate, and very often the client returns to a previously held job. The provision of medical and surgical services to clients is an effective means of gaining a large number of rehabilitations. DVR is successful with over 80% of these clients. However, since few clients requiring routine surgery are severely disabled, this type of rehabilitation effort potentially conflicts with federal service mandates.

Training. The second type of service is vocational training which is most often used in dealing with emotionally or mentally disabled clients. These cases generally involve young people with little or no work history, and many are school age children with behavior problems. Other disability groups which tend to receive training are the nonsevere visual and hearing cases and the mildly retarded.

Training cases are expensive, as shown in the following illustration, and the case files reviewed showed that some are not well managed. In one case for example, a drug addicted client who already had a vocational skill was given a complete undergraduate and graduate education at a cost of over $10,000. Undoubtedly, rehabilitation of young, emotionally disabled, and vocational disadvantaged clients is a difficult process. Nevertheless, it is clear that improved management control is necessary to minimize excessive or unnecessary training expenditures. Supervisors need to routinely review all plans which commit DVR to financing long term and expensive training programs.

COMPARATIVE REHABILITATION COSTS FOR DVR SPONSORED TRAINING



Job Development and Placement (pp. 57-61)

Job placement is probably the single most important service that a client receives. Placement may involve convincing an employer that a handicapped client is trained and can do the work. In some cases, it may require that a job be engineered to fit the capabilities of the client. Despite its importance, placement is the weakest element in the DVR service delivery system. JLARC's case file analysis showed that the counselor was responsible or assisted in job placement in only 14 of the 120 cases reviewed. Instead, counselors tended to allow clients to do their own job hunting. Counselors should receive more training in job development and placement techniques, and improvements in this area should be a high priority for supervisory review.

PROGRAM IMPACT

Once a client is accepted for rehabilitation, the agency data system only provides for the individual to be reported as "rehabilitated" or "not rehabilitated". To claim a successful rehabilitation, counselors must determine that clients remain continuously employed for 60 days. For many clients with severe disabilities, this may be a real test of the rehabilitation and job placement efforts. However, many mildly disabled persons can obtain employment without extensive placement assistance. In addition, many of these persons return to the same or similar jobs without having received significant rehabilitation services. Nevertheless, all of these cases are reported as being rehabilitated without regard to the benefit of vocational rehabilitation services.

Lack of Substantial Impact (pp. 64-66)

More than one-third of the 120 case files reviewed were judged as not benefiting substantially from DVR services; however, they were closed as rehabilitated. That is, the client could have been reasonably expected to return to employment without DVR intervention. Many of these cases were made eligible on the basis of a mild emotional or mental disorder and received little or no service. None of the case files in question received extensive counseling, and none of the clients were reported as placed in employment through DVR efforts. If a service was provided, it generally involved the purchase of relatively minor items such as eyeglasses, clothing, shoes, or tools. Some of the cases did involve substantial expenditures; but the service was unrelated to the job at closure.

DVR needs to upgrade case monitoring to include a supervisory review aimed at identifying counselors that appear to concentrate on easy closures. This review could also serve as a systematic check of program impact by assessing the counselor's contribution to the client's rehabilitation and the extent to which the client benefited.

Income Changes (pp. 63-64)

A traditional measure of program impact is comparing client earnings between referral and the point when the client is rehabilitated. Using this measure, DVR reported a 750% increase for the 1974-75 biennium. However, since 40% of all FY 1975 rehabilitants were in school or institutionalized at referral, this type of comparison is not a meaningful measure. Furthermore, actual client income at referral is not a reliable measure of earning potential. It was found that client earnings over a longer period would better reflect the individual's income. A more accurate measure of earnings requires that data on client earning potential be available through use of records such as income tax returns. Additionally, data should clearly differentiate between those clients who were previously employed and those who, because of school or institutionalization, could not have had an income at referral.

JLARC did find notable direct short term impact on one group--the disabled public assistance recipients. According to DVR records, 979 rehabilitated clients in FY 1975 received State supported welfare payments at referral and over half were removed from the welfare roles at closure. This amounts to an annual reduction of about $1,035,000 in welfare payments. DVR also had some success in reducing the amount of welfare received by clients who were not completely removed from the welfare rolls. The average monthly payment to clients who remained on welfare decreased by $11 per client or about $63,000 annually. Thus, DVR services appear to have some positive impact on the economic well-being of welfare clients even though some may not be removed completely from the welfare rolls.

Long Term Impact (pp. 66-81)

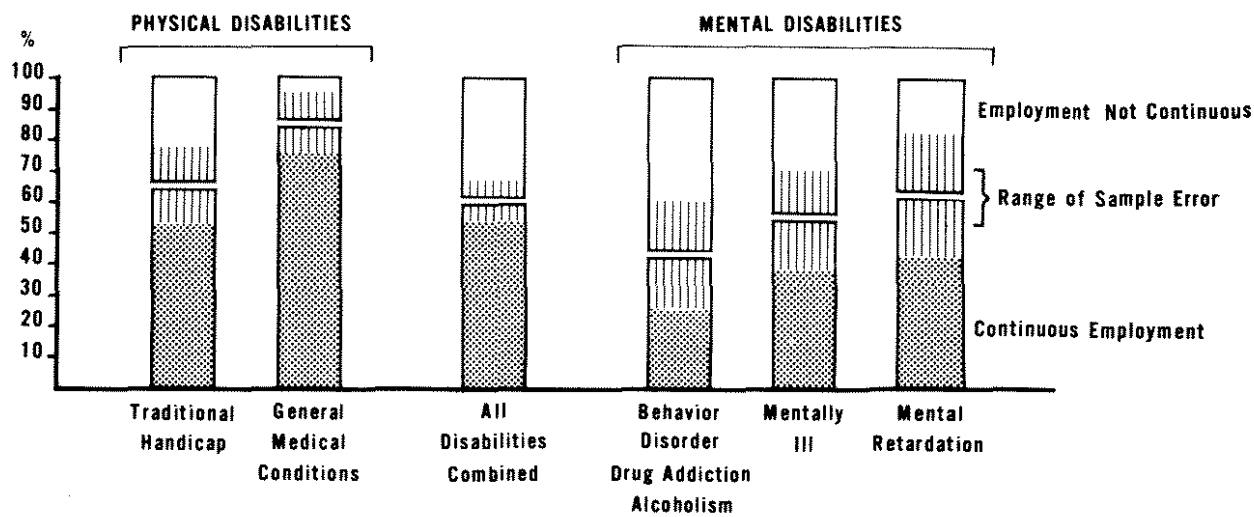
Basic to vocational rehabilitation is the idea that clients placed in competitive employment will remain employed and experience increased economic independence. An employment follow-up of rehabilitated clients was used to

measure long term impact on successfully rehabilitated clients. Income and employment data were collected for clients closed in competitive wage-paying jobs. The two measures of employment and income were used to assess three groups: all rehabilitated clients, the severely disabled, and those clients rehabilitated through one of DVR's special units.

Employment and Income (pp. 66-72)

About 18% of all rehabilitants who found wage-paying jobs in 1975 became unemployed within one year after their reported rehabilitation. Over a longer period, the attrition rate increased to 33%. On this basis, it is estimated that one-third of all DVR clients will fail to remain employed over the long term. There were significant variations within the sampled group. Clients who required primarily physical restoration services for routine medical conditions remained employed in 88% of all cases. This supports the general finding that physical restoration cases are very likely to be successful. Conversely, only 43% of all behavior, drug, and alcohol disabled clients remained steadily employed which is consistent with the finding that behavior disordered clients, although DVR's largest client group, are the least likely to benefit from rehabilitation services.

EMPLOYMENT LEVELS OF SUCCESSFUL REHABILITANTS--
FY 1975



Although two-thirds of all clients do remain employed, they generally earn a subsistence wage. For all clients who remained employed, the average annual income was $4,600. This low income characteristic is not altered by the client's contact with DVR. In 1975, 89% of the rehabilitated clients had a family income of under $6,000 when referred. This did not change much after rehabilitation since 82% of those who were working still earned less than $6,000. Thus, although a client's earning potential can be restored by a successful rehabilitation, DVR services probably do not improve the individual or family income level. In most cases, clients return to a low-paying job or show very slight income gains.

The Severely Disabled (pp. 72-76)

The most encouraging finding of the follow-up was that the physically severely disabled are as likely to remain employed as the average client and, if employment is retained, they can expect to earn relatively good incomes. Of the severely disabled with a physical handicap, 55% remained steadily employed compared to about 60% for all clients. Earnings for these clients averaged $8,000 annually which is the highest average income for any single group of rehabilitants. It is clear that this group has substantial employment potential and can benefit from services.

The severely disabled who are mentally handicapped do not do as well as the average rehabilitation client. However, this finding is not surprising given the employment problems created by this type of disability. The severely mentally ill remain employed at almost the same rate as the average client (53% to 60%). However, their earnings average only $3,600 annually. The severely retarded remain employed in 43% of all cases at about the same income level ($3,700).

Clients of Special Units (pp. 76-80)

Through a series of cooperative agreements, DVR has established units with school districts, mental hospitals, correctional facilities, and welfare offices. These units were designed to serve the specialized needs of these clients. The employment follow-up shows that special unit clients generally have no more success than do the general field office clients. With the exception of correctional units, there are no striking differences in the levels of employment found among the different special unit clients. Similarly, there is no significant difference in the levels of employment between special unit clients and those rehabilitated through a general field unit. However, the low incomes of correctional and welfare unit clients indicate that these units may not be having the long term impact intended. Similarly, the low employment levels among correctional unit clients tends to confirm DVR's decision to terminate special units located at corrections facilities.

For the sample drawn from correctional units, the results indicate that these units failed to make a significant contribution to the rehabilitation of correctional inmates. Clients from this sample remained employed in only 44% of all cases and earned the lowest incomes of any sampled group at an average of $2,300 a year. Thus, the ex-offender seems to derive little, if any, benefit from vocational rehabilitation services.

VIRGINIA COMMISSION FOR THE VISUALLY HANDICAPPED

Blindness and visual handicaps create special rehabilitation problems for individuals with vocational potential. The Commission (VCVH) operates a number of service programs for the blind and visually handicapped including a vocational rehabilitation program. In 1975, the Commission reported that 643 persons had been rehabilitated. JLARC found that the vocational rehabilitation program of VCVH often provides service to older clients with limited vocational potential, despite evidence that there are work-aged persons who need and could benefit from rehabilitation services.

Service Delivery (pp. 117-119)

The Commission for the Visually Handicapped provides generally two types of service to rehabilitation clients: physical restoration and adjustment training.

Restoration was provided to about 663 clients in 1975. JLARC sampled VCVH case files and found that restoration cases generally involve eye surgery, or the purchase of eyeglasses or prothesis.

Adjustment training is provided to clients, particularly older clients, who are having difficulty adjusting to lost or failing eyesight. These individuals are often clients of both the Vocational Rehabilitation Department and the Rehabilitation Teaching Program of VCVH. In practice, the rehabilitation teacher provides most of the service while the vocational rehabilitation counselor underwrites the cost of services.

As a result of this arrangement, the vocational rehabilitation program of VCVH serves many older clients who have limited vocational potential. This is shown by the fact that 13% of VCVH's 1975 rehabilitants were 65 or older at the time of referral. Furthermore, few of the rehabilitants obtain wage-paying jobs. Instead, most clients are closed as homemakers (45%) or unpaid family workers (15%).

Scope of the Unmet Need

An analysis of need based on VCVH's estimating formula indicates that over the last ten years, 3,000 persons between the ages of 15 and 64 have become eligible for vocational rehabilitation but have not been rehabilitated. These individuals usually have greater vocational potential than persons over 65. There is evidence of an unmet need which should take precedence over the provision of vocational rehabilitation services to the elderly. Priority should be given to serving work-age persons with vocational rehabilitation funds, and better outreach methods for finding these clients should be developed.

CONCLUSION

Virginia's two rehabilitation agencies play an important role in compensating for handicaps that would otherwise limit an individuals' employment potential. This is a desirable public function since it restores individual productivity and also removes many from dependence on their families, charity, or the State. To obtain better performance from vocational rehabilitation programs, certain major adjustments need to be made. The Department of Vocational Rehabilitation has already initiated several changes based on deficiencies noted in earlier reviews. This review validated many of those earlier findings. In addition, new information was presented which points out other program shortcomings. These need to be addressed if the rehabilitation function is to be adequately carried out. The most important areas in need of improvement are:

- Controls over counselor expenditures,

- Delegation of authority to middle-level managers;
- Closer supervision over purchases made by counselors;
- The development of a priority system, which will shift emphasis from serving large numbers of minimally disabled clients and towards the most severely handicapped;
- Control over eligibility in order to serve the severely disabled;
- Improved program management of the wide range of services that are available; and
- Development of a more effective job placement program.

The Commission for the Visually Handicapped should put more emphasis on providing vocational rehabilitation to those in the conventional work age population.

Estimates show that the number of handicapped Virginians, eligible for services, far exceeds either DVR's or VCVH's capability to rehabilitate them. This places a special requirement on each agency to service those most in need first. Also, as a public function, there needs to be a very careful use of the limited State and federal funds made available to meet these needs. Through sound planning and management of these programs, the Commonwealth should be able to achieve maximum results from available resources.

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FOREWORD

The General Assembly has authorized the Joint Legislative Audit and Review Commission to conduct operational and performance evaluations of State agencies and programs. JLARC projects are designed to assess the extent to which legislative intent is being met as well as to comment on the efficiency and effectiveness of program activity. This evaluation deals with vocational rehabilitation programs in the Commonwealth.

Rehabilitation programs may be directed at several public goals. The fundamental purpose of vocational rehabilitation is to assist handicapped individuals obtain employment. Federal legislation, regulations and initiatives have directed program management and service delivery; but, the Commonwealth can play an important role, especially in setting administrative policies, establishing client selection priorities, and managing service delivery. Most important is the need to employ and retain a professional cadre of counselors to deliver service. The Commonwealth is fortunate to have many that the JLARC staff found to be committed, interested, and knowledgeable.

The handicapped are served by two agencies--the Department of Vocational Rehabilitation and the Commission for the Visually Handicapped. Both agencies and programs have been the subject of major statutory changes in recent years. And, numerous State and federal reviews, audits, and investigations have pointed out administrative deficiencies that require correction. This evaluation, in part, assesses the degree to which the desired changes have occured. In past years, DVR management had not been able to keep pace with the programs rapid growth. Recently, under new agency leadership, the initial steps necessary to respond to key management problems appear to have been taken. It is essential that the Board of Vocational Rehabilitation and the General Assembly continue to closely monitor progress to ensure that planned changes do result in a more efficient and effective program.

JLARC procedures specify that agencies be informed of the progress of each review. On October 13, 1976, appropriate agencies and officials were provided a preliminary draft report for comment as part of an extensive validation process. JLARC staff also met with DVR and VCVH to discuss functional sections at length. A number of helpful suggestions were made and appropriate revisions have been incorporated in the final report. Some written comments were submitted and are included in the Appendix.

On behalf of the Commission staff, I wish to acknowledge the cooperation and assistance provided by each agency contacted during this study. Special appreciation is extended to the staff of the Department of Vocational Rehabilitation and the Commission for the Visually Handicapped for assistance during the review and for commenting in detail on the findings of the report.

Ray D. Pethtel

Ray D. Pethtel
Director

November 9, 1976

INTRODUCTION

Federal legislation specifying the purposes of vocational rehabilitation programs has generally directed program content and orientation. In addition, expanded funding and more liberal eligibility requirements have enabled these programs to grow far beyond serving crippled World War I veterans, which was the original intent. Over the last decade rehabilitation expenditures in Virginia have grown by four times and the range of clients served is from public assistance recipients to clients with spinal cord injuries. Currently an eligible client may receive any number of a comprehensive range of services in order to compensate for his disabling condition.

Eligibility requirements were tightened considerably in 1973 when new ammendments placed a priority of service on the severely disabled. At this same point organizational reviews of Virginia's Department of Vocational Rehabilitation started increasing. This evaluation examines these reviews and in addition utilizes new information in order to assess program performance.

When a client is accepted for rehabilitation he enters an elaborate monitoring system that will eventually either report that he is successfully or unsuccessfully rehabilitated. Out of every 100 clients that are referred, 45 are found eligible and 28 are successfully rehabilitated. This evaluation reviews the client service delivery system and how it is managed. Recommendations for improving key aspects are made.

I. INTRODUCTION

Vocational rehabilitation is among the oldest of all federal grant-in-aid programs. Originally, it was designed to serve crippled veterans, but was soon expanded to include people injured in industrial accidents. Today, the program offers a comprehensive range of services to a broad group of clients; and, while the definition of "handicap" has been expanded over time, there has been little change in fundamental program objectives--to help disabled individuals overcome vocational handicaps and become employed.

Virginia has participated in vocational rehabilitation activities since 1920. Until 1965, however, program growth was slow. At that time, amendments to the 1920 Vocational Rehabilitation Act greatly expanded eligibility and increased the proportion of federal financing. Simultaneously, Virginia's general vocational rehabilitation effort was organized as a department of state government, and a period of rapid growth occurred. Expenditures for the Department of Vocational Rehabilitation (DVR) as shown below quadrupled from $7 million to over $27 million in less than ten years, and 87,256 persons have been reported as successfully rehabilitated.

Table 1

DEPARTMENT OF VOCATIONAL REHABILITATION
1967-1975

Fiscal Year	Expenditures	Rehabilitants
1967	$ 7,050,227	5,175
1968	9,957,940	6,452
1969	13,093,597	7,700
1970	16,818,535	9,139
1971	17,918,622	10,537
1972	21,111,445	12,221
1973	22,584,247	13,246
1974	21,950,519	13,647
1975	27,054,056	9,139

Source: DVR Annual and Summary of Case Service Reports, 1967-75.

The need for rehabilitation services is clear. According to national health surveys and statewide projections, there are approximately 500,000 handicapped persons between the ages of 18 and 64 in Virginia, of which about 100,000 are thought eligible for service.[1] An additional 15,000 persons become eligible for rehabilitation each year because of illness, industrial injury, or other disabling conditions. Even though the handicapped population estimates are constant relative to population growth, DVR policies have changed the characteristics of clients accepted. More mental and emotional disabilities are being served now than earlier. In 1967, about 15% of all rehabilitants were mentally or emotionally disturbed. Since 1973, the proportion has grown to over 50%. In terms of people served, most referrals to DVR are young, undereducated, and unemployed.

Legislative Intent

The legislative goals for vocational rehabilitation programs in Virginia rely almost exclusively on provisions contained in the federal 1973 Rehabilitation Act. The General Assembly has added little specific program guidance about vocational rehabilitation except to state that DVR should:

> ...study the problems of vocational rehabilitation to organize, supervise, and otherwise provide the necessary services and facilities required to prepare persons disabled in industry or otherwise for useful and productive lives including suitable employment.

In this context, the nature of program development and the establishment of priority disability groups have been a matter of agency choice or federal mandate.

A substantial change in vocational rehabilitation programs occurred with the Rehabilitation Act of 1973 which stressed service to severely disabled clients. This change resulted from interest group pressure on Congress to prioritize service to the severely disabled and away from persons judged to be less disabled. Previous amendments to the Vocational Rehabilitation Act had broadened eligibility to include behavioral disorders and various social and cultural handicaps. Rehabilitation programs had been felt to be so successful with a traditional clientele that they were authorized to provide services to "nontraditional" clients such as corrections inmates. Even though the focus shifted to a severe disability population in 1973, the objective of employment was not altered. But, employment could be either gainful or renumerative thus including such unpaid vocations as a sheltered workshop employee, homemaker, or family companion.

In addition to an emphasis on the severely disabled, additional aspects of legislative intent can be developed from the 1973 Act:

(1) *That services provided to clients realistically enhance their employment potential within a reasonable period of time.* In other words, rehabilitation services should not be provided to individuals who cannot realistically be expected to become or remain employed. On the other hand, it is explicit that the handicap not be so minimal that it does not act as a major barrier to employment. Medical or psychological treatment should not be provided solely on a humanitarian basis without a corresponding expectation that an increase in employability will occur. Also, while there are no legal age limits services are generally intended for individuals in the work-age population.

(2) *That the range of services available to an eligible individual be sufficiently comprehensive to ensure rehabilitation.* Federal law lists fourteen services which should be made available to a client as required. Services include such diverse activities as counseling, physical restoration, transportation and training, purchase of tools, uniforms, occupational licenses, and job placement. The exact mix of services depends on the needs of each client and the judgement of the rehabilitation counselor.

(3) *That services be provided to all eligible individuals if possible, or that selection of clients be ordered and prioritized if sufficient resources*

are not available. First priority must be given to the severely disabled. The State may establish additional priority groups; however, the order of selection must be predetermined and followed in order to prevent capricious or biased acceptance of one individual over another.

(4) *That the provision of rehabilitation services be planned, coherent and involve the client in the planning process*. An Individualized Written Rehabilitation Program is to be prepared for each client. Goals, services to be provided, responsibility for cost, timing, and a means of assessing progress must be documented in the plan which is signed by the client to certify participation and concurrence.

Finally, rehabilitants should be capable of maintaining a competitive wage-paying job in order to become or remain independent and reduce dependence on family, charity, or the State for economic support. While this objective is not explicit in either State or federal legislation, it is routinely used by rehabilitation agencies as a measure of the benefits received from their activities.

The Rehabilitation Process

During the rehabilitation process, a client moves through a complex system of categories which accounts for every change in status. The illustration on the following page shows the 21 technical case codes now in use and the number of persons that entered key categories during FY 1975. These case codes have been grouped into four general categories for analysis including referral, applicant, client, and closure status.

Referral Status. An individual is kept in referral status until background information has been collected from the individual or through a referring agency. Nine out of ten individuals referred for service are identified by a public agency or other organization.

Applicant Status. After an application for service is made, the counselor obtains appropriate medical or psychological diagnostic information to determine eligibility. In the event additional in-depth diagnostic information is necessary, an applicant can be held in extended evaluation for up to 18 months. Individuals may be closed at this point if they are judged ineligible or refuse service.

Client Status. When the individual has been declared eligible for service, the counselor and client jointly prepare a plan which details how the rehabilitation is to be accomplished. A client may require only counseling and job placement or a more extensive rehabilitation plan may need to be prepared which can include: medical, psychological or therapeutic treatment; provision of a prosthetic or orthopedic appliance; prevocational, vocational or adjustment training; or other purchased goods and services. Within a reasonable time period, the client should be ready to be employed, placed, and begin a 60 day trial work period.

Closure Status. Clients who remain employed for at least 60 days are considered successfully rehabilitated and closed. An unsuccessful closure may be reported if a client can not be placed in employment or does not remain

CASE CODES AND CLASSIFICATION

Individuals Served in FY 1975

Code	00	Referral

- 34,271 referrals made to DVR

Code	02	Applicant
	06	Eighteen-month Extended Evaluation
	08	Closed from Referral

- 26,524 applicants acknowledged
- 18,771 persons found ineligible and closed

Code	10	Program Development (IWRP planning)
	12	Program Development Completed
	14	Guidance, Counseling, and Placement
	16	Physical and Mental Restoration Services
	18	Training Services
	20	Ready for Employment
	22	In Employment
	24	Service Interrupted

- 15,533 persons found eligible
- 14,864 rehabilitation plans completed

Code	26	Closed Rehabilitated
	28	Closed not Rehabilitated AFTER Rehabilitation Program Initiated (Status 14 through 24)
	30	Closed not Rehabilitated BEFORE Rehabilitation Program Initiated (Status 10 through 12)

- 9,139 successful rehabilitants were closed
- 4,745 closed unsuccessfully after program
- 567 closed unsuccessfully before program

Code	31	Cases Transferred Out
	32	Post-Employment Service
	33	Cases Transferred In
	35	Stable Employment Achieved
	37	Case Re-opened as New Referral from Post-Employment
	39	Other Post-Employment Service Terminations

- Miscellaneous codes for interim tracking

Source: Adapted by JLARC from DVR Operating Procedures Manual and DVR Workload Report, June, 1975.

employed for the 60 day period. One out of every three clients were recorded as closed unsuccessfully in FY 1975.

ORGANIZATION

There are two agencies which deal with vocational rehabilitation in the Commonwealth, the Department of Vocational Rehabilitation, and the Virginia Commission for the Visually Handicapped (VCVH). Although the bulk of this evaluation deals with DVR activities, Chapter 6 reviews the vocational rehabilitation program of VCVH.

Department of Vocational Rehabilitation

The Department was created as a separate State agency in 1964. It is governed by a seven member Board which is appointed by the Governor and vested with policy-making authority. The Board appoints a Commissioner responsible for general administration, coordination, and integration of all departmental activities. DVR is organized functionally into five divisions. In 1975 there were 74 field units located throughout the State of which 29 were general purpose units and 45 were special units. Figure 1 provides an overview of the DVR organization at the division level (Appendix 1 shows the detailed organization of DVR).

The *Division of Administrative Services* is responsible for accounting, budget preparation, fiscal records and reporting, data processing, personnel, property, and purchasing. The division provides support services to the department through preparation of two documents--the Master List of Clients and Case Cost Report. These documents currently provide the most important factual base for both financial and program information and control.

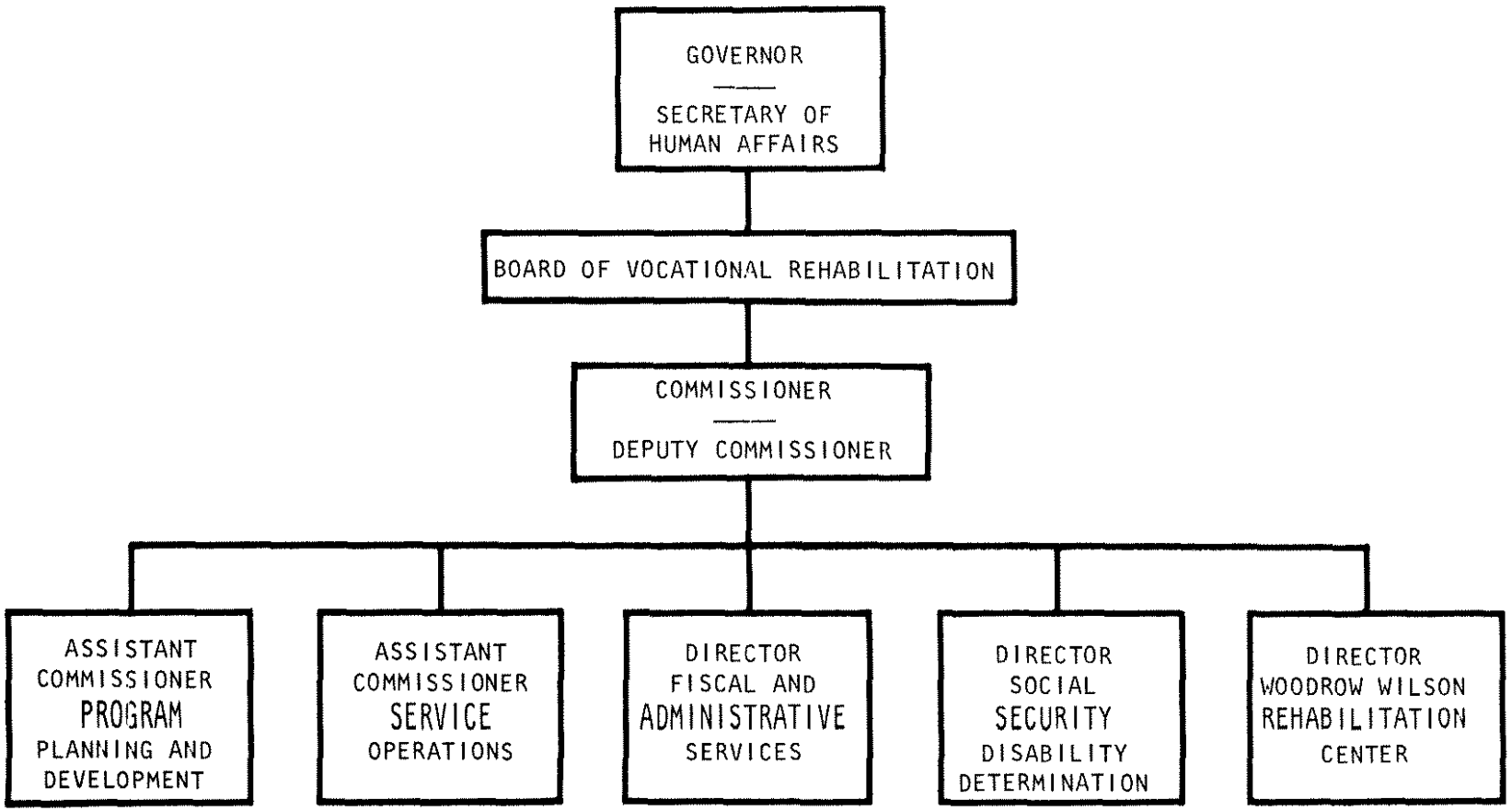
The *Division of Program Planning and Development* deals with problems related to vocational rehabilitation and promotes the optimal utilization of agency resources to meet client needs. The functional areas of responsibility are statewide and special studies, program and financial planning, and program development. A recent innovation in the division is the development of a Program Evaluation Unit to increase program accountability as required by federal evaluation standards.

The *Division of Rehabilitation Service Operations* manages the general service delivery program. There are approximately 220 counselors in the field offices who are responsible for ensuring that appropriate services are made available to all eligible clients. The administration of service delivery is decentralized through four Regional Directors headquartered in Roanoke (Region I), Annandale (Region II), Richmond (Region III), and Norfolk (Region IV). The Regional Directors are generally responsible for all service delivery activities in their geographic area. In most management situations, the Regional Directors are limited to recommending actions to an Assistant Commissioner.

The *Woodrow Wilson Rehabilitation Center* was the first comprehensive State-owned facility in the country. This facility was intended to serve the most severely disabled clients who could not be accommodated in their home

Figure 1

DEPARTMENT OF VOCATIONAL REHABILITATION ORGANIZATION CHART



Source: Department of Vocational Rehabilitation, August 1, 1975.

community. A major building program was recently concluded and facilities now consist of two dormitories, dining hall, clinical-professional services building, vocational training building, and medical services and administration building.

Although over 95% of the Center's students are referred and funded by DVR, the Center also accepts privately funded clients, clients of other Virginia agencies, and clients of vocational rehabilitation programs from other states. In FY 1975, the Center enrolled 2,128 persons. About 462 clients were in residence at any one time.

The Center is an accredited medical facility, but it is primarily designed to offer therapy, vocational evaluation, and training. Vocational preparation is provided in a controlled environment which also assists the individual in adjusting socially and personally to a handicap. Clients may receive training in one of 25 vocational areas such as welding, industrial sewing, drafting, construction trade helpers, or upholstery. Costs are apportioned on a per-diem basis with a flexible rate schedule to account for each kind of service mix. Fees range from approximately $20 a day to over $50 (for clients who use the medical facility). About 80% of all Woodrow Wilson funding comes through purchase of service agreements arranged by DVR counselors for their clients. In FY 1975, total income exceeded $5.36 million.

The *Disability Determination Division* adjudicates claims for Social Security benefits under three programs: Social Security Disability Insurance (SSDI), Supplemental Security Income (SSI), and Black Lung Disability Benefits. Four DVR counselors in the division screen all SSDI, SSI, and black lung applicants for possible participation in the vocational rehabilitation program and refer them to field counselors. In FY 1975, approximately 12,000 Social Security cases were referred to DVR. The cost of maintaining this Division (approximately $4 million in FY 1975) is supported entirely by federal funds.

A new capability of DVR, not shown as part of the organization, results from the establishment of four evaluation centers. The centers will be used to provide short-term, intensive evaluation of an individual's vocational potential. The centers are located in Richmond, Norfolk, Roanoke, and Bailey's Crossroads. The Richmond evaluation center is operated by DVR while the other three are privately operated under contract to the State. Currently, DVR is in the process of assuming direct control of each evaluation center as funds permit.

Since its beginning in 1964, DVR has experienced considerable growth in terms of clients, personnel, and expanded responsibility to serve clients jointly with other organizations. Much of this growth is attributed to DVR's attractive financing, since 80% of the agency's field program is funded by federal grants. An important growth characteristic has been an increase in the number and type of cooperative and special units which provide rehabiliitation services to individuals within institutions, schools, and certain local agencies. (Appendix 2 details this growth.) The increase occurred primarily between 1964 and 1973 along with expanded funding and eligibility criteria. Special units were developed first in mental hospitals and public schools and later in welfare and drug abuse units.

Virginia Commission for the Visually Handicapped

The organization of VCVH is smaller than DVR in terms of personnel, but much broader in terms of functions. Vocational rehabilitation is just one service provided to the legally blind and visually handicapped. Other services include:

- Education for visually impaired students;
- Library and reading services;
- Assessment of needs through a Social Service Unit;
- Eye Health Services; and,
- Rehabilitation Teaching Program to assist in developing adaptive and adjustment skills.

Vocational rehabilitation service is administered by a Deputy Director using field counselors who arrange for appropriate services for eligible clients. In addition, VCVH uses three specific kinds of programs in vocational rehabilitation activities.

- The Rehabilitation Center for the Blind, located in Richmond, provides intensive evaluation, psycho-social services, adjustment training, and vocational assessment services to the severely visually handicapped.
- Virginia Industries for the Blind operates facilities in Charlottesville and Richmond, and provides the opportunity for gainful employment for visually handicapped individuals. Employees earn regular salaries based on their production.
- The Business Enterprise Program trains and finds employment for the visually handicapped who qualify to work in one of 74 vending stands operated under the program.

In FY 1975, the Commission served 3,233 persons in vocational rehabilitation programs and reported 643 successful rehabilitants.

PROGRAM AND MANAGEMENT REVIEWS

Program Reviews

Vocational rehabilitation programs have been extensively reviewed on a national and State level over the last eight years. The first study that established many administrative procedures and program directions now used by Virginia was the 1968 report of the Governor's Study Commission on Vocational Rehabilitation. This comprehensive report dealt with assessing the need for vocational rehabilitation and developed a plan to address those needs. A key problem identified by the Commission was "...coordinating the many services

available to vocational rehabilitation clients." The Commission recommended more effective intra-agency and inter-agency coordination and cooperation.

Nationally, the U. S. General Accounting Office (GAO) examined the effectiveness of vocational rehabilitation and found a need to better define the population requiring services and the number who annually become handicapped. The GAO reported:

> Even though large and increasing numbers of persons are reported rehabilitated, this does not necessarily mean that these persons are or should be considered capable of becoming self-sufficient or competitive with nonhandicapped persons. Some of the clients rehabilitated might not be those who most need the program in view of (1) the large universe of need and (2) the minor nature of services provided to some successful clients.[2]

The GAO findings were used in support of the 1973 Rehabilitation Act which led to the new emphasis on serving the severely disabled.

Over the last two years, the DVR program was also tested for technical compliance by an HEW audit covering FY 1973 and 1974 and a follow-up audit by the Rehabilitation Services Administration (RSA). Both federal reviews suggested ways to improve client service delivery.

Management Reviews

The management of DVR came under special scrutiny when alleged misappropriation of funds by counselors was discovered. A State Police investigation led to several indictments and convictions (some appeals are pending). A Grand Jury issued a highly critical report in December, 1974, which resulted in a subsequent evaluation of departmental policies and procedures by the DVR Board.

Two chronic management weaknesses which were identified through various review processes need to be understood at the outset--the lack of budget controls and "the quota system". Both of these concepts play an important part in later discussion and analysis.

Budget Controls. A basic administrative deficiency became apparent in November, 1975, when DVR determined that a moratorium was required on client case services. At that time, nearly all case service funds had been spent or encumbered, yet more than half of the fiscal year remained. DVR's financial history had been characterized by uninterrupted financial growth. That growth, however, was not accompanied by increasingly responsive financial and program controls. In a financial audit for FY 1972 and 1973, the Auditor of Public Accounts stated "it was evident that the accounting procedures and internal controls had not been developed in keeping with the increased financial responsibility of the Department". Although the agency responded by issuing guidelines about supervisory responsibility for counselor expenditures, these actions proved to be inadequate to prevent the most recent budget encumbrance problem and resulting moratorium.

Counselor Productivity. A second management concern was a result of an implied quota system. A Board survey found that nine out of ten counselors had felt undue pressure to produce successful rehabilitations. The survey was conducted as part of the follow-up to the Grand Jury investigation. This pressure was also encountered during the course of the JLARC review in that two-thirds of the counselors interviewed indicated they continue to feel pressure to close large numbers of clients. The "quota system" pressures counselors to produce a large quantity of successful rehabilitants without a corresponding emphasis on quality. The results are obvious. In many instances, clients with disabilities that are easy to rehabilitate receive priority attention and service. The fact that a quota system can be interpreted by counselors to still exist is easily understood. In December, 1975, the Assistant Commissioner of Operations circulated a directive which formalized minimum acceptable production standards for successful rehabilitations--without a corresponding measure for casework quality. In view of this kind of management pronouncement, DVR's capacity to adequately serve the handicapped, particularly the severely disabled, is jeopardized.

Evaluation Purposes and Methods

Previous reviews of DVR have usually focused on a specific technical program or management area. This evaluation has been made to give the General Assembly a comprehensive and independent assessment of Virginia's vocational rehabilitation programs and has several components. Among these are:

- An assessment of available information which shows the number of Virginians in need of vocational rehabilitation programs and the way in which they enter the system;
- A review of the eligibility mechanism to determine if it functions so that intended clients are accepted;
- An assessment of the services provided DVR clients in terms of how they are planned, financed, and ways they benefit the recipient;
- An analysis to determine whether clients remain employed and become economically independent once they are rehabilitated;
- An assessment of the effectiveness of the organization of DVR in controlling counselor expenditures, budgets, and performance.

Most information used in this evaluation was collected from records supplied by DVR and VCVH. In addition, JLARC staff interviewed personnel in both the State and field offices. Field work was extensive and included interviews with each of DVR's four regional directors, approximately half of the counselors and 28 of DVR's 38 supervisors. Additional program information was gathered from DVR's extensive data files of financial, client, and caseload information.

In order to interpret the data, JLARC staff carried out four surveys in the following areas:

- A survey of agencies was made to develop information about the extent of cooperation with DVR in referring or placing clients.

- A wage and employment survey was made to determine whether clients who are successfully rehabilitated stay on the job and earn incomes that allow them to become economically independent.

- A random sample of cases for clients successfully rehabilitated in FY 1975 was made to assess service delivery.

- A client survey was made to validate service delivery and to gather client reactions to rehabilitation benefits.

A technical appendix has been prepared to explain, in detail, the methodology and techniques involved in each survey.

NEED, REFERAL, AND ELIGIBILITY

In Virginia there are 105,000 disabled people in need of vocational rehabilitation. The number grows annually by about 15,000 as more become disabled through disease or accident. Since the Department of Vocational Rehabilitation cannot realistically serve and rehabilitate this many, it is critical that clients most in need of services be accepted first. The referral source will play an important part in this process. It was found that nine out of ten clients are referred by another agency or organization. These agencies include the Social Security Administration, local health departments, hospitals, schools, and welfare offices. Through management of these various referral sources, DVR should be able to serve clients in relation to the type of priorities that they wish to address.

Clients become eligible if: (1) there is a diagnosed disability, (2) the disability is a substantial handicap to employment, and (3) there is a reasonable expectation that the services will benefit the individual's employablility. Key weaknesses in applying these criteria have been not fully documenting each of the criteria and the way the substantial handicap criteria has been used. Poor use of this criteria has enabled many clients with minimal disabilities to be served.

This chapter discusses the principal types of clients served by DVR--the traditional handicaps, general medical conditions, personality disorders, mentally ill, and the mentally retarded. Each of these groups is examined along the lines of cost, rehabilitation rate, and proportion that are severely disabled. Service to clients with severe disabilities will need to be carefully monitored by DVR in coming years. When the federal law emphasizing the severely disabled was implemented, Virginia lagged far behind other states in service to this group.

II. NEED, REFERRAL, AND ELIGIBILITY

Federal and State law requires that the total number and needs of handicapped individuals be assessed and that the relative need for rehabilitation by different segments of the handicapped population be determined.[1] JLARC examined existing national and statewide surveys that analyze the need for vocational rehabilitation and found estimates of disabled persons in Virginia range from about 240,000 to 700,000 with the number of persons eligible for rehabilitation services ranging between 91,500 and 152,000. For purposes of this review, JLARC concurs with DVR that there are approximately 500,000 disabled persons, of which 105,000 are eligible to be DVR clients. (A survey of the severely disabled population indicates there are probably 100,000 persons in this disability category although there is no reliable estimate of the proportion that may or may not be eligible for service.)

DVR estimates need based on a methodology first used by the Governor's Study Commission on Vocational Rehabilitation. Estimates are updated annually using revised population statistics. A national study of various need assessment methods was made by the Urban Institute in 1975 which concluded that the method used by the Social Security Administration was the most reliable because disability was defined in the most authoritative fashion. Reconciling the two estimating methods, however, indicates there is little substantial difference in the projected total disabled population. A comparison between the results of the two methods is shown in Table 2. While comparison between survey results are made difficult by variations in data collection procedures and differences in age and disability definition, the estimates are useful to determine if there is a gap between persons served and the handicapped population. Appendix 3 provides an overview of the various projection surveys.

Table 2

ESTIMATES OF VIRGINIA'S DISABLED POPULATION

	Total Disabled	Eligible Disabled
DVR (1975)	477,300	84,300
DVR (1977)	531,275	105,998
Urban Institute as used by DVR	534,131	NA

Source: DVR "Report on the Workgroup on Client Identification", April, 1974 and "Agency Planning Guidance for FY 1976-77, Annex B."

In addition to population totals, it is important to consider the number of persons that are added to the handicapped population annually by disease or accident. DVR estimates there are 36,800 disabled cases added to the total population each year, of which about 15,000 are eligible for service. This estimate is supported by a recent GAO report showing that approximately 912,000 persons become disabled nationally each year; and, based on Virginia's population, this figure would translate to about 21,000.[2]

Regardless of whether the estimates are precise or not, the magnitude of difference between the eligible population (105,000), the annual increment (15,000), and persons rehabilitated by DVR indicates the department cannot realistically serve all eligible persons with available resources. Even using the more conservative figure, DVR is losing ground in terms of successfully dealing with the disabled. During its most productive year (1974), DVR successfully rehabilitated about 13,600 clients--a figure which is 1,400 persons below the estimated annual increment. This shortfall emphasizes the need for sound service priorities and careful management in order to ensure maximum use of the service delivery capacity and optimum benefit to those in need.

THE REFERRAL PROCESS

The referral network managed by DVR plays a key role in the rehabilitation process because it is through emphasis of particular referral sources that service goals and priorities can be implemented. JLARC reviewed DVR's existing referral system and found it was comprehensive and provides statewide coverage. Nevertheless, changing priorities and new federal mandates will require substantial restructuring. This restructuring in fact began in FY 1976 with the elimination of two special programs which were not serving high priority disabilities.

The present referral system is based on a recommendation made by the Governor's Study Commission. A principal finding of the study was a widespread lack of understanding about vocational rehabilitation programs among the various social service organizations that should have been key sources of DVR referrals. The Commission made several recommendations to improve knowledge about DVR including the establishment of formal agreements between DVR and other agencies such as hospitals, educational institutions, health agencies, and the Industrial Commission. Such agreements were felt to be an important method to improve interagency contact and to assure a stable flow of referrals. Eventually, DVR signed cooperative agreements at the State level with the Virginia Employment Commission, and the departments of Health, Mental Health and Mental Retardation, Corrections, Education, and Welfare.

The pattern of cooperative agreements and the development of many special units for provision of service to specific target populations set the direction for the type of program currently administered by DVR. Of particular importance is the growth in the number of mentally disabled, personality disorder, drug, and alcohol cases brought into the DVR system through these cooperative agreements. Specifically, the growth of four types of special units at correction, mental health, school, and drug treatment facilities was primarily responsible for changing the composition of DVR referrals in past years.

The Referral Network

Most DVR counselors are assigned a travel itinerary which includes a regular schedule of visits to employment offices, schools, welfare and public health offices, hospitals, and similar organizations. Each field office supervisor divides his territory among the counselors in the office to ensure all areas are covered. Specialized counselors, such as those assigned to a mental hospital or school unit serve only that source of referrals.

Approximately 90% of all clients are referred from one of the various organizations that form the referral network. This indicates that the referral system is highly structured and that few DVR clients would be aware of vocational rehabilitation without it. Because of the importance of the network, each referral source is described in the following section beginning with the largest and most complex agency, the Social Security Administration.

Social Security. Some persons receiving benefits under either the Social Security Disability Insurance (SSDI) or Supplementary Security Income (SSI) program are eligible for rehabilitation services. If a determination is made that an individual might become independent of social security benefits through vocational rehabilitation, the Social Security Administration will finance 100% of the costs incurred. (This includes the cost of counselor time and administrative overhead.)

Under the Social Security Act, each state is responsible for determining eligibility for disability benefits. Virginia, like most other states, places this function in its vocational rehabilitation agency, and as a routine part of the process to determine eligibility for social security the individual is also screened for possible rehabilitation eligibility. There are four disability division counselors assigned to examine cases to see if they are appropriate for referral. In FY 1975, these four counselors screened approximately 36,000 cases and, in turn, referred one-third to a field office for review. However, even though many are referred, few social security applicants are accepted for service. For example, in FY 1975, out of 8,481 social security cases referred to DVR and closed in one of the various status codes, just 6% (526 cases) were found eligible for service. The balance were closed as ineligible. An analysis of ineligible closures showed that:

- 4,164 persons refused rehabilitation service;
- 1,680 persons were too disabled for service;
- 773 persons could not be located; and
- 312 persons were not handicapped.

Obviously, DVR, in cooperation with the Social Security Administration, could profitably explore ways to improve the prescreening process especially if the screening can reduce the large number of referrals who refuse rehabilitation service.[3]

Welfare. There are ten special welfare units which are located at Arlington, Chesapeake, Chesterfield County, Danville, Halifax, Marion, Norfolk, Portsmouth, Richmond, and Roanoke. In 1975, 24 counselors were assigned special welfare caseloads. Areas without a specialized welfare unit handle these cases as part of its general caseload.

Where special units exist, a team casework approach is usually taken by using a DVR counselor, a counselor aide, and a social worker. The DVR counselor handles the normal vocational rehabilitation services (evaluation, counseling, restoration, training, and job placement), while the social worker assists the client with welfare matters and provides other supportive services. Referrals from a welfare source represent the second largest group in FY 1975 and, in terms of a diagnosed disability, they were the largest. A discontinuance of public assistance recipients as a mandated federal priority will result in less extensive use of this source.

Schools. School referrals are often the result of counselor initiatives; however, DVR has cooperative agreements with several local school divisions and has established special units with Alexandria, Richmond, Roanoke County Chesterfield, Charlottesville, and Albemarle schools. (Agreements with Harrisonburg/Rockingham and Fairfax County schools were terminated after the 1975-76 school year.) In FY 1975, 30 counselors were assigned to special school units. The rest of the State is covered by counselors as one stop on their itinerary.

Schools are generally visited during the spring to inform graduating seniors of DVR services, although counselors visit special education and vocational education classes regularly during the year to work with clients. School age referrals, except those in special units, are not usually accepted until their senior year or when they otherwise leave school.

Corrections. DVR first entered the corrections area in 1965 when they agreed to provide rehabilitation services at the Natural Bridge Learning Center. Later, the program was expanded to include the Beaumont School for Boys and Bon Air School for Girls, the Southampton Farm, the Chesapeake Jail, and the Federal Reformatory at Petersburg. By 1975, there were 16 specialized counselors in these units. Generally, DVR provides guidance, job placement, and items such as tools and clothing to assist each inmate and juvenile offender as they returned to the community. Until recently, DVR also provided vocational education instructors, but this training was recently taken over by the Rehabilitative School Authority. In October, 1975, DVR decided to terminate the special units at correctional facilities because of the large number of low priority behavior disorder cases referred.

Mental Health. DVR has cooperative agreements with the Department of Mental Health and Mental Retardation, the four State hospitals, the Lynchburg Training Center, the Roanoke Valley Mental Health Service, and the City of Richmond. Individual DVR counselors have been assigned to the Southside Training Center for the Mentally Retarded at Petersburg as well as the Northern Virginia Mental Health Institute, and recently to the Southeastern, and Southwestern Training Centers. A total of 28 counselors had specialized mental health caseloads in 1975. Many other referrals are made to general field counselors by local mental health clinics.

Physicians. Medical and psychiatric doctors act as another major source of referrals. During JLARC field office interviews, several counselors reported they have developed contacts with local doctors who referred low income persons to DVR when they require surgery. In this type of case, DVR generally underwrites the cost of surgery.

Health. Referrals from local health agencies result primarily from informal arrangements between a local DVR office and city or county health departments and hospitals. In two cases--MCV and U. Va. hospitals--DVR has assigned a counselor to monitor, assist, and refer eligible clients.

Table 3 shows the nature of cases closed during 1975 by source of referral. Key concentrations of disabilities are highlighted. A review of the statistics clearly indicates that each agency in the referral network tends to refer similar types of disabilities. Planned development and utilization of the referral network can greatly assist in obtaining a desired mixture of clients based on intended priorities to be served. Perhaps most important is that

Table 3

CASES CLOSED IN 1975 BY REFERRAL SOURCE AND DISABILITY

REFERRAL SOURCE

PHYSICAL DISABILITIES	Welfare	Education	Self-Referral	Corrections	Mental Health	Physicians	Health	Social Security	Another Individual	Other Sources	Rehabilitation Facilities	VEC	Industrial Commission	Artificial Appliance Co.
Visual	1%	3%	2%	--%	--%	--%	1%	1%	3%	4%	--%	4%	2%	--%
Hearing	1	2	4	--	--	1	3	1	5	8	1	4	--	(47)
Orthopedic	19	9	(23)	1	--	22	20	(36)	18	16	11	(27)	(87)	(49)
General Medical	(30)	17	(29)	2	3	(66)	(48)	(41)	(31)	22	13	(26)	9	4
MENTAL DISABILITIES														
Psychological	8	2	11	2	(66)	6	10	11	9	5	19	9	2	--
Mental Retardation	13	(38)	10	8	6	--	2	5	12	11	9	9	--	--
Personality	(28)	(29)	21	(87)	25	5	16	5	(22)	(34)	(47)	21	--	--
TOTAL NUMBER	3657	3423	2946	2732	2456	2380	2088	1524	1031	837	451	388	257	116

Note: Only cases with a diagnosed primary disability are included.

Source: JLARC Analysis of RSA-300,1974-75

monitoring of the network can be useful in sorting out low priority categories. For example, DVR's elimination of the corrections units can be viewed as an effective way to reduce the referral of low priority personality disorder clients since 87% of the 2,732 cases in 1975 were in that category.

DVR should take steps to make a referral analysis available to supervisors, and JLARC recommends that DVR periodically prepare a detailed analysis of eligible cases by referral source on a regional or field office basis to assist counselors and supervisors to plan the most effective itinerary.

ELIGIBILITY FOR REHABILITATION SERVICES

Determination of eligibility for vocational rehabilitation is the responsibility of individual counselors who obtain documentary evidence from many sources, including medical and psychological evaluations, social histories, and employment records. Eligibility is based on the client's meeting three conditions:

1. There must be a diagnosed physical or mental disability;

2. The disability must constitute a substantial handicap to employment; and

3. There must be, in the counselor's opinion, a reasonable expectation that services will benefit an individual's employability.

Each condition must be satisfied before an applicant is accepted for service by either DVR or VCVH.

The first condition, *determination of a disability*, requires documentation from a medical professional. Prior to 1973, it was possible for a counselor to identify certain types of disabilities, particularly ones involving emotional disorder and mental retardation, without professional consultation. Documenting the other criteria of a substantial handicap and reasonable expectation of employability has been and remains the responsibility of the counselor. As such, satisfying these two criteria is dependent on the professional competance and judgement of each counselor.

A *substantial handicap* to employment is defined in law as a disability which prevents an individual from obtaining, retaining, or preparing for employment consistent with his or her capacity and ability.[4] Thus, consideration must be given to the individual's educational and vocational background as well as to existing job skills and experience. The mere presence of a physical or mental condition (regardless of severity), does not by itself constitute a vocational handicap. Conversely, a relatively minor medical condition can be a substantial handicap if it limits an individual's vocational potential. For example, a congenital hernia may be a substantial handicap if an individual's employment requires heavy lifting; it may not be a handicap for employment requiring only desk work.

The criterion, *reasonable employment expectation*, means that the handicap which limits employment can be removed or alleviated by medical

treatment, training, or another service provided by the rehabilitation agency. Mental or physical conditions which are rapidly progressive, terminal, or too severe to realistically allow the individual to engage in some form of vocational activity are sufficient grounds to find persons ineligible.

As part of this review, the JLARC staff looked at the eligibility determinations made by DVR counselors in each of 120 client cases closed in FY 1975. A random sample of case files was selected from throughout the State. The sample selection methodology was designed to ensure the cases represented a cross section of DVR clientele. (The Technical Appendix explains the selection process in detail.) Analysis of the case files indicated that the criteria of (1) diagnosed condition and (2) reasonable employment expectation were met in each case. However, available evidence did not indicate that the substantial handicap criterion was consistently met. Counselor decisions were often so poorly documented that it was nearly impossible for anyone (including DVR) to adequately evaluate the eligibility determination process.

Definition of Substantial Handicap

The criterion of a substantial handicap is the weakest part of DVR's eligibility determination process. Poor use of this criterion has also been a point of concern to federal auditors since the enactment of the 1973 Rehabilitation Act. While the Act was intended to make guidelines sufficiently flexible to permit State agencies to provide service to a variety of handicapped individuals, DVR has not made full use of the control features included in the guidelines. As a result, DVR serves many marginally handicapped persons who may not be substantially handicapped.

JLARC found five indications that the substantial handicap criterion is not being used effectively by DVR. They are:

- A 1974 audit of DVR by HEW;
- A 1975 audit of DVR by RSA;
- A 1975 RSA memorandum on the minimally handicapped;
- Analysis of the reasons given for DVR's ineligible closures; and
- JLARC's review of 120 case files.

Federal audits of the Department of Vocational Rehabilitation carried out in 1974 and 1975 focused heavily on eligibility. A performance audit of DVR made by HEW and released in final form in November, 1975, found that 25% of the cases reviewed did not appear to meet at least one of the three basic criteria for eligibility.[5] The report used case studies to demonstrate instances where the substantial handicap criterion was not met. This finding, in conjunction with several others in the report, was considered sufficiently serious to justify the preparation and circulation of an Information Memorandum dated May 24, 1974, relating the preliminary findings of the Virginia audit to the HEW Regional and Central office. The concern generated by this memorandum and the preliminary draft of the audit brought about a follow-up audit by the Rehabilitation Services Administration (RSA).

The RSA audit was released in January, 1975, and covered the same time period as the original HEW audit (July, 1972 - June, 1973).[6] The audit also found problems with the manner in which eligibility was established. In the

opinion of the RSA auditors, one out of ten cases were of questionable eligibility, many because there was not sufficient documentation.

In 1975, RSA also circulated a memorandum which dealt with clients whose primary disability would be considered mild without additional justifying information. These "mild" disabilities included such problems as dental conditions, hernias, hay fever and asthma, ulcers, varicose veins, hemorrhoids, hypertension, alcoholism, drug addiction, mild retardation, and behavior disorders.[7] RSA was concerned about the tendency of rehabilitation agencies to focus on "disability groups which, on the surface, seem much more likely than other disability groups to include clients whose disabilities might be expected to produce minimal vocational handicapping effects".[8] RSA focused on seven disability groups which, despite some exceptions, do not "in and of themselves often constitute a substantial handicap to employment".[9] Using comparative statistics from FY 1973, Virginia was found to be the third highest among all the states in the proportion of rehabilitants in these seven problem categories. Half of all FY 1973 rehabilitations credited to DVR were classified in one of the seven categories of concern to RSA. Since individual case data were not used in the RSA analysis, conclusive judgements were not made as to whether or not the substantial handicap criterion was violated. However, it was clear that RSA felt that agencies with high concentrations of minimally handicapped clients were not adequately using the substantial handicap criterion in determining eligibility.

An analysis of DVR's reasons for finding clients ineligible also indicates that the substantial handicap criterion is rarely used by counselors. Of all applicants who advanced far enough in the DVR system to have a disability diagnosed, only 8% were found ineligible because they were not substantially handicapped. It is apparent that, in almost all cases, an applicant with any disability will be accepted for service with the substantial handicap criterion given only cursory consideration.

In its own review, JLARC found seven cases which clearly were not substantially handicapped and did not require DVR intervention. One such case is described below.

Case Number 2-1

> *A sophomore at a major state university was referred to DVR after injuring a thumb during gym class. The physician reported that in addition to the thumb injury, there was a congenital malformation of the shoulders. No restrictions or treatment was recommended. The medical report noted that movement, circulation, and sensation were normal, and no treatment was required at the time although surgery at a later date was a possibility. The medical report recommended that activities involving strenuous use of the upper extremities such as carrying loads on either shoulder should be avoided.*
>
> *A DVR counselor declared the client eligible for rehabilitation service due to a "severe impairment of the use of both shoulders", and because there was a limitation recommended regarding carrying weight on the shoulders. DVR paid $1,560*

for the client's last two year's tuition and books. The client's vocational objective was to be a mathematics teacher.

This case did not require DVR intervention because the client was already successfully enrolled in college for an occupation which was not limited by the handicap. A rehabilitation service was not required. Medical treatment was not provided to correct the shoulder malformation. There is no evidence that the client would not have completed the university program without DVR assistance.

Eligibility determination is difficult to evaluate because of the judgements involved. However, there is sufficient evidence to bring into question the way DVR uses the substantial handicap criterion in determining eligibility. Poor use of this guideline has allowed DVR to serve many marginally handicapped persons. Federal auditors have found that at least 10% of DVR clients are ineligible and the evidence indicates that this is a conservative figure. Also, the problem is increased by poor case file documentation.

Case File Documentation

Although DVR has a strong commitment to case audits, the process has been limited to technical and compliance aspects. The lack of qualitative documentation found during JLARC's case file review makes the frequent departmental audits meaningless in terms of varifying the extent to which counselor eligibility judgements are consistent with departmental goals, objectives, and priorities. Insufficient documentation was found to be a problem with three general categories of handicaps. In each area, general medical, psychological, and personality handicaps, a different aspect of the documentation shortcoming was observed.

General Medical Handicaps. About one out of five cases reviewed involved medical conditions such as cysts, benign tumors, varicose veins, and general problems of the musculoskeletal system. These conditions were often defined by counselors as creating a substantial handicap to employment because of pain, discomfort, or limitation of the ability to bend, stoop, or move freely. The extent of the disability, particularly whether it posed a substantial handicap, was usually found to be unsupported. In each case, however, the counselor noted on the certificate of eligibility that the diagnosed medical condition did constitute a substantial handicap due to pain or limitation; therefore, the client was in need of service.

There was not enough information in the file to support or refute the counselor's judgement that a substantial handicap existed. This lack of information prevents the exercise of supervisory control of the acceptance process. The counselor should be held responsible for not only obtaining diagnostic evaluations but also for providing the medical or psychological evaluator with information on the kinds of findings that are necessary to justify State intervention. Otherwise, the medical report may "describe a disability in terms of the generic disablement and not in the context of the client as the handicapped individual."[10] One example of a poorly documented general medical case is presented below.

Case Number 2-2

> *A 20 year old client with several years experience as a sheetmetal worker was referred to DVR with a pilonidal cyst which the counselor reported caused "extreme pain when bending, lifting, or sitting." The file contained two medical examinations made on the same day. The first report confirmed the cyst but indicated there was no restriction to employment. The second report recommended no work at all. Neither of the examining physicians reported any pain or discomfort caused by the cyst which the client had known about for six years.*
>
> *DVR paid $890 for surgical removal of the cyst.*

It is not possible to make a judgement about client eligibility in this case because of the lack of confirming information. This is partly a deficiency of the reporting forms used by DVR. Currently, the DVR medical form (VR-3) has only two lines for medical comments concerning employment restriction. JLARC's case file review found that these recommendations were sparsely utilized with insufficient detail to substantiate many handicaps and, as in the case cited, conflicting recommendations from two physicians based on examinations given the same day. DVR should require more specific diagnostic information from examining professionals to ensure that both a disability exists and that it is a substantial handicap to employment. Therefore, JLARC recommends that counselors ensure that examining medical professionals specify the way in which a condition is a handicap to the clients' employment. This medical statement can be accommodated by providing additional space on a revised VR-3 form.

Psychological Conditions. A second area of concern in regard to the actual nature of a handicap occurs in diagnosis of psychoneurotic ailments. Words such as anxiety, instability, immaturity, ego weakness, and depression are terms frequently used in psychological reports, and are frequently used by counselors as "keywords" which are underlined in diagnostic reports and transferred verbatum to certificates of eligibility. Once again, there is virtually no additional documentation provided to relate the severity of psychological symptoms to the manner in which they affect a client's employment.

Personality Disorders. Personality disorders are a third category which are typically poorly documented. Psychological reports, particularly those received from school psychologists, are routinely accepted by counselors as a basis for eligibility. Behavior marked by brooding, depression, irritability, and temper outbursts is sufficient to support a diagnosis of an "adjustment reaction to adolescence" which is used in most school-aged cases. Personality disorder conditions can also include such handicaps as resentment, antisocial behavior, social ineptness, poor judgement, instability, and a lack of physical or emotional stamina. Decisions about the disabling nature of these handicaps are particularly difficult to critique because they are mostly used in cases where the client is too young to have work experience. In these cases, counselors argue that the individual's vocational potential is handicapped.

A major part of DVR's commitment to serving clients with personality disorders is intervention in cases where a vocational handicap is only speculative. School-aged clients, correctional inmates, and the institutionalized

mentally ill are examples of clients who may have a potential rather than a proven vocational handicap. In fact, these clients accounted for about 40% of DVR's FY 1975 successful rehabilitants. Emphasis on habilitation (qualifying for employment) instead of rehabilitation, further weakens the substantial handicap criterion.

As with physical disabilities, DVR should require professionals examining psychological and personality disorder cases to specify how a particular diagnosed condition acts as a substantial handicap to employment.

CLIENT SERVICE PATTERNS

DVR has developed five identifiable patterns of service which reflect program direction and result both from the growth of special units and the attitudes of counselors and supervisors. The new mandate to serve the severely disabled sometimes cuts across or at times conflicts with the service patterns. About three out of four DVR clients served in 1975 were not severely disabled, and the types of disabilities DVR rehabilitates is considerably different than one might expect. These patterns of service and the share of FY 1975 rehabilitations they represent can be classified as follows:

- *traditional handicaps (19%)*--amputees, blind, deaf, and the orthopedically deformed;
- *general medical handicaps (32%)*--hospitalization and surgery for low income workers who are not eligible for Medicaid but qualify financially for State-supported service;
- *personality disorder handicaps (25%)*--persons with emotional and character disorders characterized by a wide range of maladaptive behavior patterns such as public offenders and juvenile delinquents. Also includes drug and alcohol abusers;
- *mentally ill handicaps (11%)*--the mentally ill, psychotics, and psychoneurotics; and
- *mentally retarded handicaps (13%)*--the mild, moderate, and severely retarded.

Table 4 describes these five service patterns and their respective financial and program characteristics. The average cost ranges from $537 for rehabilitating a personality disorder to $1,069 for one of the traditional handicaps. Other important factors include the rehabilitation rate which is highest for clients with medical conditions (78%) and traditional handicaps (72%) and lowest for the personality disordered (53%) and mentally ill (52%). A final significant factor is the proportion of severly disabled clients that are in the five categories. The mentally ill had the highest proportion--60%--while the general medical conditions had the lowest at 8%.

Table 4

COMPARATIVE MEASURES OF FIVE PROGRAM ORIENTATIONS

Major Disability Category	Number of Eligible Closures	Number of Rehabilitations	Rehabilitation Rate	Case Service Expenditures	Average Cost Per Rehabilitation[1]	Number of Severely Disabled Rehabilitations[2]	Percent of Severe Cases Rehabilitated in Category
Traditional Handicaps	2,428	1,738	71.6%	$2,439,598	$1,069	628	36.1%
Medical Conditions	3,698	2,901	78.4%	2,607,483	789	229	7.9%
Personality Disorders	4,311	2,289	53.1%	1,581,664	537	297	13.0%
Mental Illness	1,932	1,007	52.1%	690,590	638	606	60.2%
Mental Retardation	2,082	1,204	57.8%	1,128,131	707	441	36.5%
Total	14,451	9,139	63.2%	$8,447,466	$ 758	2,201	24.1%

[1]When expenditures were required.
[2]About 2% of the severely disabled are not included due to coding errors. Also, JLARC considers some of the severely disabled to be incorrectly identified, particularly the personality disorder cases.

Source: DVR Summary of Case Service Reports, 1975 and JLARC analysis of DVR computerized records.

The disabilities and other key characteristics of these service patterns are summarized below.

"Traditional" Handicaps. DVR served and closed 2,428 traditionally handicapped clients in FY 1975. The table below shows each category of traditional handicapping conditions. Seven out of ten persons in this category were successfully rehabilitated. As a group, traditional handicaps require the largest expenditure of case service funds averaging $1,069 per successful closure.

TRADITIONAL HANDICAPPING CONDITIONS

Disability	Eligible Closures	Successful Rehabilitants
Blindness both eyes	20	12
Blindness in one eye	54	38
Other visual impairment	58	42
Deafness	165	132
Other hearing impairment	231	199
Orthopedic impairment of the limbs	1,066	758
Spinal cord injury	90	60
Multiple schlerosis	10	6
Muscular dystrophy	4	2
Other ill-defined orthopedic impairment	507	332
Amputation or loss of limbs	206	145
Amputation or loss of body parts	17	12
Total	2,428	1,738

Some caution needs to be exercised in generalizing from the labels used to describe disabilities in this group. For instance, cases closed as having an orthopedic impairment of the limbs were observed to be clients whose disability ranged from permanent crippling to ingrown toenails. Generally, however, handicaps based on visual, hearing, or orthopedic disabilities are the source of many of the most severely disabled clients. In FY 1975, approximately 628 cases in this category were identified as severe in accordance with RSA regulations for the identification of the severely disabled.

General Medical Handicaps. This category generally covers conditions caused by diseases or other medical conditions. DVR closed 3,698 eligible cases in this category in FY 1975 with 2,901 (78.4%) being successfully rehabilitated. The major disabilities in this category are shown in the following table along with the number of rehabilitations for FY 1975.

DVR clients with these disabilities are generally older than the average DVR rehabilitant. Most clients come from low income backgrounds (89% had an annual family income of less than $6,000 at referral) and cannot afford health insurance although most do not qualify for Medicaid. Services received are primarily surgical, and clients require less time in an active status than most rehabilitants (11.4 months compared to 16.5 months). An average general medical rehabilitation costs $789.

SELECTED GENERAL MEDICAL HANDICAPS

Disability	Eligible Closures	Successful Rehabilitants
Conditions of the genito-urinary system	779	698
Benign tumors	332	298
Dental conditions	309	281
Conditions of the digestive system	275	227
Hernias	269	219
Cardiac and circulatory conditions	231	144
Varicose veins/hemorrhoids	151	112
Hay fever/allergies	132	107
Epilepsy	175	103

Personality Disorders. The largest single disability category in terms of clients rehabilitated are those individuals handicapped by personality, emotional, and character disorders. One out of every five rehabilitations in FY 1975 was classified in this category. When alcoholism and drug addiction are included in this category, this service pattern accounts for 25% of all rehabilitants. RSA generally combines these two disabilities into one category although the physiological symptoms of addiction are recognized and treated in the course of the rehabilitation. DVR closed 365 alcohol and 344 drug abusers in FY 1975 from an eligible status, with 170 and 208 respectively being rehabilitated. The combined total eligible personality disorder, alcoholism, and drug addiction cases was 4,311, and 2,289 were successfully rehabilitated.

Personality disorder cases which are eventually rehabilitated originate primarily from four types of DVR units. Virtually all of the 612 rehabilitations of DVR correctional units were personality disorder cases. In addition, welfare counselors generated 315 rehabilitations with a personality disorder, and school counselors had approximately 400 cases. The nine counselors specializing in drug abuse reported 155 rehabilitations. Services for this category cost $1,581,664 or $537 for each successful rehabilitant.

Mentally Ill. In FY 1975, DVR closed 1,932 eligible cases diagnosed as mentally ill. Just over half were successfully rehabilitated. Most of the mentally ill were clients of one of DVR's special units at the four State mental hospitals, the Northern Virginia Mental Health Institute or the Catawba Geriatric Workshop. A common procedure followed in releasing a mental patient is to transfer them to a general DVR field office counselor near their home for job placement and closure.

Mental illness is frequently identified as a severe disability although, by itself, it is not automatically considered severe under federal law. Overall, six out of ten mentally ill cases were considered severely disabled by DVR in FY 1975. Of the two general forms of mental illness recognized by DVR, three quarters of all psychotics were regarded as severe while only a third of all psychoneurotics were regarded as severe. The reason for the large number of severely disabled codings in this disability category is the breadth of the severity identification guidelines used by the RSA for mental illness. Current institutionalization or a history of institutional treatment in conjunction with

daily medication or mild disturbances in behavior are sufficient to qualify a case as being severe. This definition provides considerable latitude when compared to many of the more narrowly defined guidelines which are applied to physical disabilities.

Mental illness cases are relatively inexpensive to rehabilitate requiring an average of $638. No expenditures were required at all for 319 rehabilitated cases.

Mental Retardation. In FY 1975, 2,082 eligible retardation cases were closed with 1,204 being rehabilitated. Retardation as a handicap can range from a mild category with IQ's as high as 85 to a severe category with IQ's as low as the 40's. The retarded clients served and rehabilitated in FY 1975 are shown below.

CLIENTS WITH MENTAL RETARDATION

Category	Eligible Closures	Rehabilitated
Mild	1,431	829
Moderate	501	290
Severe	150	85
Total	2,082	1,204

Conclusion

These five service patterns grew out of the relatively loose client selection policies under which DVR operates. To a certain degree this results from only one-fourth of all clients being in a federally mandated priority. The order of selection for the remaining eligible clients are at the State's discretion. The General Assembly may wish to guide or participate in the priorities selected beyond those that are federally designated. In doing so, factors to be considered instead of the client's disability are cost, program performance, and impact on all public resources. A framework for developing this priority setting process is more fully discussed in Chapter 5.

EMPHASIS ON THE SEVERELY DISABLED

The five service patterns discussed above represent the way DVR developed under the flexible legislative guidelines which previously existed at the federal level and with minimum State legislative involvement. The recent federal mandate requiring highest priority for the severely disabled will cause several major shifts in orientation. The new mandate was superimposed on existing agency programs; and, as seen in Table 4, the proportion of clients who can be considered severely disabled ranges from 60% for the mentally ill to less than 8% for clients with a general medical condition. It is important to note that legislative intent requires that each State rehabilitation agency actively

seek out the severely disabled. Furthermore, no eligible severely disabled client is to be denied service if resources are available (agencies were specifically advised by RSA to budget so that severe clients will be served). It is not intended, however, that the severely disabled be served to the exclusion of all other disability groups.

Finding the Severely Disabled

An important factor in making the transition to serving severely disabled clients will be to determine which referral sources are most likely to come in contact with this type of client. The description of a severe disability is shown on the following page and Table 5 shows that certain sources refer the largest number of severe cases. Clearly, some balance needs to be achieved between referral agencies that produce high numbers of severely disabled and agencies that are most likely to have clients meeting the severely disabled definition. It is equally important that DVR also continue to develop and upgrade its outreach programs so that information about departmental services is widespread since many severely disabled clients are self-referred.

In evaluating DVR's plans for FY 1977 in light of these considerations, it appears that the management decisions made for this fiscal year satisfy the need to serve more severely disabled persons. Elimination of the special

Table 5

SEVERELY DISABLED BY REFERRAL SOURCE
FY 1974-1975

Referral Source	Severely Disabled[1]	Rank	Percent of all Referred Cases Which Were Severe	Rank
Mental Health	862	1	35.1%	2
Welfare	656	2	17.9	9
Self-Referral	620	3	21.0	7
Social Security	584	4	38.3	1
Schools	544	5	15.9	12
Health	352	6	16.9	10
Physician	265	7	11.1	13
Other Individual	218	8	21.1	6
Other	152	9	18.4	8
Other Health	138	10	30.6	3
Corrections	73	11	2.7	14
VEC	63	12	16.2	11
Industrial Commission	55	13	21.4	5
Artificial Appliance	34	14	29.3	4
Total	4,616		19.0%	

[1]All personality disability cases have been deleted because of the erroneous coding found for this group.

Source: JLARC Analysis of RSA-300, FY 1975.

DESCRIPTION OF THE SEVERELY DISABLED

There are four criteria which determine whether or not a client is severely disabled. They are:

- if an individual is diagnosed as having one of the following disabilities, he is automatically classified as severely disabled: amputation, blindness, cancer, cerebral palsy, cystic fibrosis, deafness, heart disease, hemiplegia, mental retardation, mental illness, multiple schlerosis, muscular dystrophy, neurological disorders, paraplegia, quadriplegia and other spinal cord conditions, renal failure, respiratory or pulmonary dysfunction.

- if the individual has a disability which is diagnosed as meeting certain qualifying conditions; e.g., epilepsy, with a record of seizure within the last two years.

- if the individual is receiving SSDI or SSI benefits from the Social Security Administration.

- if the individual case involved documented evidence of loss and limitation which can be classified as a "functional limitation."

Functional limitations may be the result of a single disability or a combination of disabilities which can be documented from both a clinical and a functional perspective as meeting both of the following criteria:

1. A substantial loss of functional capacity and restriction of activity attributable to medical factors, such that the client:

   - Is unable to make use of public bus or train, or
   - Is unable to perform sustained work activity of six hours or more, or
   - Has disfigurement or deformity so pronounced as to cause social rejection, or
   - Speech is unintelligble to nonfamily members, or
   - Is unable to climb one flight of stairs or walk 100 yards on the level without pause, or
   - Has loss of manual dexterity or coordination sufficient that he is unable to button buttons, wind a watch, or write intelligibly; and

2. The client will normally require multiple vocational rehabilitation services over an extended period of time.

Source: 45 USC 401.1(w)(3) and definition of functional limitations from Rehabilitation Services Manual, "Statistical Reporting System", July, 1974.

corrections and drug units and subsequent counselor reassignment is supported by the finding that only 3% of corrections referrals are severely disabled. DVR has planned to increase service emphasis to the deinstitutionalized mentally ill and patients of the State's two teaching hospitals. The high proportion of severely disabled referrals from mental health facilities (35%), indicates that the increased emphasis is likely to result in more severely disabled clients being found.

Identification of the Severely Disabled in Virginia

During FY 1975, DVR served approximately 16,000 clients identified as severely disabled. This was one-fourth of the total 66,000 clients who received services during the year. In addition, DVR reports that of the 9,139 successful rehabilitations for FY 1975, 2,239 or one-fourth were severely disabled cases.

During this review, the JLARC staff found a number of examples of severely disabled rehabilitations reported by counselors which do not meet the federal definition. For example, a review of all FY 1975 closures of severely disabled cases found that 263 cases had a personality disorder as a primary disability. Of these, 228 cases did not satisfy the federal definition by having a multiple disability or a Social Security status which would explain their severe coding. About two-thirds of these cases were inmates of the Petersburg Reformatory and were clients of the DVR special unit at that institution.

Rehabilitation personnel at RSA confirmed that few, if any, of these personality disorder cases could be identified as severely disabled under either the letter or intent of the 1973 Act. Furthermore, according to RSA, the personality disorder handicap is the one major category of greatest concern to federal evaluators since it often produces a minimal or insubstantial handicap.[11]

A critique of all severely disabled cases which required a counselor judgement for eligibility was not conducted; however, some misconceptions about identification of the severely disabled were found during field interviews. For example, some counselors stated that a client could be coded severe if the case had only a multiple disability. Such coding, however, would not meet the definition. For example, a mildly retarded client with a personality disorder may be a difficult rehabilitation case but might not meet any of the functional limitation criteria required in order to be coded as severe. DVR should make every effort to ensure that all counselor judgements about severity are based on consistent understanding of definitions and guidelines. To do so, DVR will have to be more concerned about validating the quality of judgements made by counselors during case audits. Consistency in this area is particularly critical since service to the severely disabled is being carefully monitored.

DVR's Commitment to the Severely Disabled

DVR has met the minimum requirements for providing services to the severely disabled under the 1973 Rehabilitation Act, including prioritizing service to the severely disabled and developing a plan for expanding and improving services to this population. While policy and program changes identified

and reported for in the 1976 State Plan are generally too new to have been fully implemented, several changes have been made. These include the decentralization of client evaluation capabilities and Social Security determination personnel, the staffing on an in-house program evaluation unit, and upgrading of training and research utilization techniques. Of potentially greater impact on the provision of services for the severely disabled are planned but not yet instituted program changes. They are designed to improve outreach through education of referral sources and other State agencies regarding the new DVR service priorities, and the development of specialized placement techniques for the severely disabled.

Interviews with DVR counselors and supervisors indicated that about half of the field personnel had misgivings about the new priority to serve the severely disabled. Few questioned the ethical needs, but frequently cited the high cost and lack of vocational potential as possible negative factors. Counselors generally felt that DVR was already serving the severely disabled who had vocational potential, and that additional time, money, and caseloads would be required if the quality of service was to increase. Also, it was a clear field staff sentiment that DVR administration would need to recognize that more severe cases correspondingly would mean fewer successful closures each year. Thus, DVR administration would not be able to rely on a "quota system" as in the past. Counselors who did see a need for additional outreach efforts on behalf of the severely disabled consistently stated that educating existing referral sources would be the most productive means of finding additional clients.

The mandate to serve the severely disabled will especially effect Virginia. This is demonstrated by the proportionately fewer severely disabled rehabilitated by DVR in FY 1975. The national average for severely disabled rehabilitants of other state vocational rehabilitation agencies was 34%, whereas Virginia had 24%. Only five states (West Virginia, North Carolina, Utah, Wyoming, and Nevada) had proportionately fewer severely disabled rehabilitants. This indicates that Virginia is lagging behind the rest of the country in serving the severely disabled. DVR hopes to increase the number of severely disabled who are rehabilitated by about 5% during FY 1977 by ending the specialized drug and correction units. At the same time, there will be an expanded intake effort in the two State supported teaching hospitals and an increase in services to the deinstitutionalized mentally ill. The development of these intake sources and concomitant restrictions on the eligibility of many personality disorder cases are expected to increase the percentage of severely disabled rehabilitations without substantially altering the operations of the DVR field office counselors. There is, however, overall dissatisfaction within the Department regarding the way the federal criteria defining the severely disabled have been developed, and it is hoped that a reevaluation at the federal level will bring about some relaxation of the guidelines.

CHARACTERISTICS OF THE DVR CLIENT

Since 1967, there have been 87,256 rehabilitations recorded by DVR. These clients have generally been young, poorly educated, and unemployed. About half of all clients were dependent on their families for support and about one-fourth were on public assistance or were in public institutions. Table 6 identifies the principal client characteristics for the period 1967 to 1975 for

Table 6

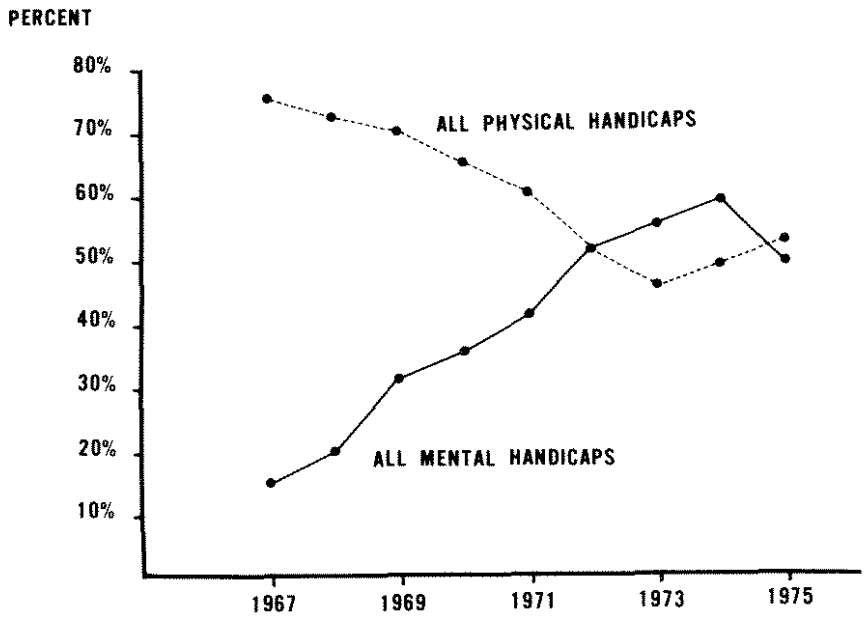
General Characteristics of Rehabilitated
DVR Clients 1967-1975

Characteristic (number of rehabilitants)	1967 (5,175)	1969 (7,700)	1971 (10,537)	1973 (13,246)	1975 (9,139)
Age at Referral					
20 or less	18.2%	28.1%	32.2%	33.9%	29.1%
20-34	31.5	29.0	30.0	36.1	38.7
35-44	22.2	18.8	16.0	13.6	14.6
45-65	27.0	23.4	21.4	16.0	17.2
over 65	1.0	.7	.4	.4	.4
Education at Referral					
8 years or less	51.1%	49.9%	42.4%	36.7%	35.2%
some high school	20.0	23.3	24.4	26.6	26.7
high school diploma	16.8	17.8	19.9	23.4	24.3
some college	3.1	3.5	5.6	6.1	8.4
other	5.0	5.5	7.7	7.2	5.3
Work Status at Referral					
competitive employment	15.6%	15.2%	12.3%	11.5%	13.9%
homemaker	15.7	8.1	6.0	6.0	7.8
other work	2.2	1.0	.7	.6	1.5
nonworking student	10.7	12.1	16.2	17.9	17.3
nonworking other	55.8	63.6	64.8	62.0	59.5
Primary Source of Support at Referral					
family and friends	65.6%	60.8%	62.5%	57.6%	54.8%
current earnings	18.3	16.5	12.8	11.1	14.1
public assistance	7.2	6.0	6.6	9.1	9.1
public institution	3.1	11.3	13.1	16.9	15.2
other	5.8	5.4	5.0	5.3	6.8
Weekly Earnings at Referral					
none	82.6%	84.5%	86.0%	87.3%	85.0%
$1 to $50	11.6	11.6	9.2	6.7	6.1
more than $50	2.0	3.9	4.8	5.9	8.9
not reported	3.8	--	--	--	--
Public Assistance Recipients at Referral					
number	477	516	784	1,502	1,043
total amount of grant	$45,173	$55,740	$113,401	$223,907	$164,430
percent of all cases	9.2%	6.7%	7.4%	11.3%	11.4%

Source: DVR summary of case service reports, 1967-1975.

Figure 2

PERCENT OF ALL REHABILITANTS BY MENTAL OR PHYSICAL DISABILITY (FY 1967-1975)



Source: DVR Case Service Summary Reports, 1967-1975.

clients closed as successfully rehabilitated. Figure 2 shows the changing orientation between physical and mental handicaps.

Several trends are clear from these data, most of which can be attributed to special unit growth in school, welfare, mental health, and corrections facilities. First, the growth in the number of rehabilitations between FY 1967-75 has been primarily due to an increase in mental or emotional handicap categories. In 1967, 15.5% of all rehabilitations had a mental or emotional disability. By 1973, the proportion of this type of rehabilitant had risen to more than half. Although there was a 33% decrease in total rehabilitations between 1973 and 1975, mentally or emotionally handicapped individuals declined by only 9%. Second, the proportion of rehabilitants who were in an institution increased from 3% in 1967 to 15% in 1975, and the percentage of nonworking students increased from 10% to 17% of the total. Finally, the average age of all rehabilitants declined dramatically. In FY 1967, half of all rehabilitants were over 35 years old while in FY 1975, more than two-thirds of all clients were under 34 years. Correspondingly, the average educational level increased with about two-thirds of all rehabilitated clients in FY 1975 having reached high school compared to less than half in FY 1967.

Rehabilitation Rate

The rehabilitation rate or the percent of all cases which are successfully closed as rehabilitated varies greatly according to disability. Table 7 shows the distribution of primary disabilities for all eligible cases closed in FY 1975. The primary disability is defined as that physical or mental condition which most directly contributes to the work limitation. As shown in the table, personality disorder cases dominate DVR's client population with mild retardation, orthopedic, and mental handicaps also very high.

In terms of the rehabilitation rate, several general medical categories such as dental conditions, digestive disorders, hernias, genito-urinary disorders, allergies, and benign neoplasms are most likely to result in a successful rehabilitation. As discussed in Chapter 3, most of these clients require only hospitalization, surgery, or treatment. These clients are also relatively simple to close successfully since they usually return to a previously held occupation.

Table 7

PRIMARY DISABILITY OF DVR CLIENTS
FY 1975

Disability	Number	Percent	Rehabilitation Rate
Personality disorder	3,602	24.9%	53.1%
Orthopedic impairment	1,677	11.6	69.1
Mild mental retardation	1,430	9.9	46.7
Psychosis	1,178	8.2	48.6
Genito-urinary disorders	779	5.4	89.6
Psychoneurosis	754	5.2	57.7
Moderate to severe retardation	651	4.5	57.6
Hearing impairment	396	2.7	83.6
Alcoholism	365	2.5	46.6
Neoplasm	349	2.4	87.4
Drug addiction	344	2.4	60.5
Dental conditions	309	2.1	90.9
Other digestive disorders	290	2.0	86.2
Hernia	269	1.9	81.4
Heart conditions	231	1.6	62.3
Amputation	223	1.5	70.4
Epilepsy	174	1.2	58.9
Varicose veins/Hemorrhoids	151	1.1	74.2
Respiratory conditions	139	1.0	68.3
Visual impairment	132	.9	69.7
Allergies	132	.9	81.1
Diabetes	121	.8	62.8
Ulcers	88	.6	78.4
Hypertension	51	.4	62.7
Other conditions	616	4.3	66.6
Total	14,451	100.0%	63.2%

Source: JLARC analysis of Federal Quarterly Report (RSA-300), FY 1975.

A final characteristic is that 2,508 clients (17.4%) had a secondary disability identified. A secondary disability is defined as a second impairment, residual defect, or other disabling condition that contributes to but is not the major basis of the employment handicap. Table 8 lists the six largest categories of secondary disability as reported for cases closed in FY 1975.

Table 8

SECONDARY DISABILITY OF ELIGIBLE DVR CLOSURES
FY 1975

Disability	Number	Percent
Personality disorder	385	15.3%
Mild mental retardation	167	6.6
Alcoholism	121	4.8
Psychoneurosis	112	4.5
Diabetes	104	4.1
Hypertension	90	3.6

Source: JLARC analysis of FY 1975 federal tapes.

CONCLUSION

DVR cannot realistically expect to meet the needs of the eligible disabled population in Virginia. The gap between rehabilitations and the number of eligible persons can be estimated at about 100,000 and has increased by over 16,000 persons since 1971 if the number of rehabilitations (58,790) is compared with the number of persons handicapped by disease or accidents annually (75,000). Given this situation, it is critical that DVR develop and implement a system of priorities that will ensure that the most severely disabled persons receive necessary services. The fact that nine out of ten referrals come from identifiable sources and that many agency referrals have definite patterns of disability and severity emphasizes the management potential inherent in the referral network.

The referral system is a key element in controlling intake. DVR's present referral network is comprehensive and based on many formal cooperative agreements. The largest referral agency--the Social Security Administration--is a good source in terms of severity, but the number of persons that never become clients of DVR indicates that additional prescreening should be used whenever possible. The Social Security Administration and DVR need to tighten the screening process to eliminate the many persons who refuse service.

The decisions made by DVR regarding ways to seek out more severely disabled referrals are supported by available data. Elimination of special corrections and drug units will not effect the number of severely disabled referrals significantly, and the corresponding reassignment of counselors can be used to more intensively cover the remaining referral sources.

DVR counselors do not adequately document their eligibility decisions on a case-by-case basis as required by DVR regulations. As a result, supervisors and internal audit teams cannot conduct meaningful management reviews of the critical eligibility determination process. This is particularly serious because DVR has been cited in the past for providing service to ineligible clients. This review found a high percentage of DVR clients still concentrated in disability categories which are likely to result in only minimally handicapping conditions. JLARC found three areas where documentation was particularly weak--general medical conditions, psychological disabilities, and personality disabilities. The fact that DVR counselors serve a particularly heavy caseload by national standards, and that the Department experienced a severe fiscal crisis in FY 1976, further highlights the need for continuous and intensive review of the eligibility determination process.

DVR is an agency which serves a wide range of clients. Many of these clients have not suffered a catastrophic disease or injury but instead may be disabled by a relatively mild and routine condition. Only one-fourth of DVR's clients fall in a federal priority and the State can essentially determine the order of selection for the balance. In this process, the General Assembly may wish to participate in the selection used by DVR. The agency should increase its public information and outreach program to ensure widespread understanding of the kinds of services available.

In 1973, DVR received a mandate to serve the severely disabled person on a priority basis. DVR has met the minimum requirements of this mandate but does not yet have a mechanism to establish a uniform commitment to this goal throughout the agency. Serious problems exist when DVR counselors do not properly identify the severely disabled. JLARC found this occurred at least once on a large scale with clients at the Petersburg Federal Reformatory. The fact that over 200 cases were miscategorized is a sign that there are management shortcomings in supervising the application of the severely disabled mandate. Additionally, DVR lagged well behind the rest of the states when the new mandate was implemented. DVR will, therefore, be required to place particular emphasis on new program changes to serve the severely disabled.

SERVICE PROVISION

Federal law specifies that vocational rehabilitation agencies should make available 14 different services including evaluation, counseling, restoration, training, and job development. The counselor and client jointly develop the exact services to be provided and the time frames for their delivery. While the counselor can offer a comprehensive range of services, in practice, clients with physical disabilities tend to receive restoration services while those with mental and emotional disabilities generally receive some form of training.

The financing of each clients rehabilitation can involve DVR paying the entire cost or using a third-party source such as a college grant to pay for some portion of the rehabilitation. In addition, if the individual's income exceeds a certain level, he or she will be expected to pay for part or all of the rehabilitation. This chapter examines the financing of the various services provided to clients. Recommendations are made to improve documentation of financial need, increase monitoring of certain high-cost cases, and to develop better information for cost-benefit analysis.

The 1973 Rehabilitation Act specified that clients with the most severe disabilities should receive each state's priority emphasis. This chapter will also review DVR performance in this important area.

Rehabilitation services can be of considerable benefit to the disabled individual. Many of the services such as surgery directly compensate for a disability. Other services such as counseling and guidance have more subjective benefits, but also can assist the client. Probably most critical to the client's economic independence is the job placement efforts of the counselor. DVR has recognized that they need to improve this area. The agency has started using specialized job placement counselors which should strengthen this aspect of their service delivery system.

III. SERVICE PROVISION

After an applicant for vocational rehabilitation has been declared eligible, a wide range of services are available which can be completely or partially supported by public funds. A counselor is responsible for identifying needed services and expediting their provision. A wide variety of vendors may be used to provide service including private firms, sheltered workshops, the Woodrow Wilson Rehabilitation Center, private or State-supported colleges and universities, hospitals, clinics, and private physicians. Finally, the counselor must make available job placement services to assure the clients' employment.

The implementing regulations for the 1973 Rehabilitation Act require that fourteen different kinds of vocational rehabilitation services be available.

- evaluation
- counseling and guidance
- physical and mental restoration
- vocational and other training
- maintenance and transportation
- services to members of the client's family
- interpreter services for the deaf
- special services for the blind
- telecommunication, sensory, and other technological aids and devices
- recruitment and training for public service employment
- placement in suitable employment
- post-employment services
- occupational licenses, tools, equipment, initial stocks, and supplies
- other goods and services which can reasonably be expected to benefit a handicapped individual in terms of employability

The extent to which each service is provided to a client is determined by DVR. Most routine service delivery procedures are described in DVR's Procedures Manual although additional policies have been included in Interagency Memos and Commissioner's letters.

Counselors have great latitude in the range of services which can be offered to a client. They may authorize payment for such items as shoes, fuel oil, customized vehicles, surgery, psychiatric care, prothesis, college tuition, workshop per diem, and on-the-job (OJT) training. Flexibility to determine the mix of services a client receives plus the wide range and variety of resources a counselor may use on behalf of his client is a major asset. It is cited by vocational rehabilitation professionals as the primary factor which distinguishes vocational rehabilitation from other human service programs such as health, welfare, or special education. The latitude open to the counselor, however, requires special attention to ensure that services are well planned and coherent.

Planning for Service Provision

The principal planning tool available to counselors is the Individualized Written Rehabilitation Program (IWRP). Mandated by the 1973

Rehabilitation Act, the IWRP describes the logical progression of events from identifying the vocational goal through job placement. Ideally, this would be the basis for the way in which the counselor and client see the rehabilitation developing. While not contractual, the IWRP does specify the responsibilities of both counselor and client in some detail. Major changes in the nature or content of the IWRP require the preparation of an amendment which must be signed by both counselor and client. The IWRP is still relatively new to DVR, and was not fully operationalized until December, 1975. However, every case in the JLARC review had either an IWRP or the previous planning document.

JLARC's review of 120 DVR cases found that the quality of service planning is not consistent. Overall, reviewers questioned the usefulness of 20 (one out of six) of the 120 plans examined. Four major shortcomings were found including cases in which:

(1) the vocational objective of the plan was unrealistic or incompatible with the client's background or the nature of the disability,

(2) the plan was prepared after the client was employed or after services were initiated,

(3) the plan called for additional training although the client possessed a saleable skill at referral which was not limited by the disability,

(4) the plan was incomplete.

Unrealistic Vocational Objective. Seven of the reviewed plans had a vocational objective which was not compatible with the client's prior experience, skills, or condition. For example:

Case Number 3-1

> *A 49 year old man with twenty years experience as an engineering technician was disabled by a back injury. The counselor specified a vocational objective as a berry farmer. The client told JLARC that he had discussed berry farming as a hobby with the counselor but had not seriously considered it as a vocation.*
>
> *The client was eventually closed as successfully rehabilitated when he returned to his former job as a technician.*

Case Number 3-2

> *A 17 year old severely retarded male with an IQ of 57 had a plan prepared for him with the vocational objective of a dental technician which required 12 months training. The client was unable to complete the training program.*

Plan Preparation After a Job Was Obtained. Twelve cases had a plan prepared by a counselor after the client had either found a job or after service delivery was initiated. For example:

Case Number 3-3

A counselor was notified by a client's family that he was working as a carpenter's helper on April 18. The counselor wrote a plan on May 7 with the vocational objective of a carpenter's helper.

Case Number 3-4

A counselor made only one entry in his field notes stating that the plan was written "to be effective March 21". The client had a different job before the plan became effective.

Case Number 3-5

A counselor was notified that the client was working on January 22 and wrote the rehabilitation plan the next day.

Training Despite a Saleable Skill. Two cases were found in which there was evidence that the client's job skills were not significantly impaired by the disability despite the fact that DVR authorized additional training.

Case Number 3-6

A DVR client who had eighteen years experience as a professional musician was disabled by drug addiction and emotional problems. The counselor authorized retraining because the client had an "outmoded" musical style. DVR paid over $10,000 for the client to attend undergraduate and graduate school.

Although the client may have been disabled by the emotional and drug problems, DVR could have encouraged a return to the previous vocation after drug therapy and treatment. JLARC feels that this is an unjustified extension of services beyond what was required for vocational rehabilitation.

Case Number 3-7

A counselor authorized welding training for a client who had experience as a miner. The client was disabled by a psychological problem unrelated to his job. The counselor justified the additional training because the client had been laid off and there was no mining job immediately available. The client's case was closed when he returned to his mining job.

Other plans were questionable because the plan itself or the client's personal background form (VR-4) were incomplete, or because the counselor failed to file amendments for major changes in the original plan (one case had evidence of four job changes and yet no amendments were filed).

In addition to reviewing plans in the case file, JLARC interviewed counselors regarding the rehabilitation planning process. Counselor opinion varied as to the value of the IWRP. A few counselors felt that the paper work requirements did not justify the benefits received. Others were particularly critical of the need to obtain client views and signatures since it involved unnecessary time delays. In addition, some counselors felt that many clients are incapable of contributing to the planning process due to the nature of their disability, particularly in the case of retardation or mental illness. However, most counselors did indicate that the IWRP forced them to think through what they intended to do for the client.

Although one out of every six plans reviewed were considered to have serious shortcomings, there were also many examples of meticulous planning and documentation. It is apparent that DVR supervisors do not monitor the plans prepared by counselors with a set of uniform standards. This is a management deficiency since the plan is the only single source of information which documents why the counselor considers the client to be eligible. Further, it shows what the counselor intends to do on behalf of the client. As such, the plan is a valuable management tool and a necessary element in case auditing. Accordingly, JLARC recommends that DVR supervisors conduct more stringent audits of IWRP's, particularly in regard to backdated plans, failing to file amendments as required by DVR policy, and identifying unrealistic vocational objectives. The purpose of this review is just as much an opportunity to train counselors as it is a chance for DVR to revise or curtail case services where possible.

Establishment of Financial Responsibility

After a client's program eligibility is determined, the counselor must decide if the client should contribute to the cost of purchasing rehabilitation services. There is no federal requirement that the financial status of a client be considered prior to the provision of DVR services. If the state agency chooses to use some form of financial needs test, federal law requires only that the process be established in writing and applied to all clients in an equitable manner. Virginia, like most states, has a financial needs test which has been developed by DVR and is administered by the counselor. If the client's income exceeds a minimum, it does not prohibit him or her from becoming a client. It may, however, require that the client provide for all or part of the cost of many of the services received during rehabilitation.

A review of DVR's financial needs test found that the standards used by DVR are so generous that most applicants receive services at full cost to the State. Furthermore, DVR's financial needs test documentation is not sufficient to prevent fraudulent application.

Financial Standards. DVR's standard for determining financial eligibility is less stringent than those of other state rehabilitation programs. The financial needs test allows a standard exemption on income and the value of personal and real property. For example, a family of four is allowed an exemption of $550 a month on income and $4,000 on the value of personal and real property. In addition, the value of the client's home and furnishings, job related property, and automobile is exempt. A survey of other vocational rehabilitation programs found these standard exemptions were similar.[1] What is unique, however, is that DVR also allows most common financial obligations to be

itemized for exemption if the client's financial assets exceed the standard exemptions. Included in these allowed itemized exemptions are rent, food, utilities, clothing, medical bills, and legally incurred debts on anything other than a luxury item. Thus, the client's financial need is judged on the basis of either a standard or itemized exemption listing, whichever is greater. Use of the itemized exemption procedure enables almost any client to be eligible to obtain service at full cost to the State. For example:

Case Number 3-8

> *A client's monthly income was $822. The standard exemption for the client and spouse is $400 which left $422 in client assets that could be used to support the cost of rehabilitation. However, the client's allowable itemized exemptions totalled $844. Since the latter figure exceeded monthly income, the client was financially eligible for full DVR payment of rehabilitation costs. The client required and received a hearing aid costing $673 and was closed as successfully rehabilitated.*

The standard exemptions used by DVR are of no value since they can be superceded by the itemized listing. Thus, DVR's financial needs test is so open-ended it can routinely operate so that nearly everyone can receive services at full cost to the State providing they spend all their income.

Some flexibility is obviously desirable in applying any financial standard to meet the needs of special hardship cases. This flexibility is provided for in other states by permitting certain "exceptional exemptions". For example, each state contacted for this review exempts medical expenditures required by the disability. Some states also exempt job related expenditures and payment for support of dependent persons away from home. Finally, other states allow a case-by-case review of unusual circumstances which may require that all financial need standards be waived. These cases are generally reviewed at a supervisory level with the nature of the exemption dependent on client circumstances. This type of flexibility ensures that a financial needs test is applied fairly while maintaining the usefulness of the standards.

DVR should eliminate the itemized exemption option as it is currently structured. If the standard exemptions are too low they should be increased. For example, Pennsylvania allows a family of four a standard exemption on income which is twice that of Virginia and an exemption on property which is three times higher. However, the standards are not superceded routinely. Moreover, each supervisor should have the authority to waive the standard exemption if necessary on a case-by-case basis, subject to review by the Regional Director.

Documenting Financial Eligibility. Virginia is not in a good position to prevent fraud since there is no verification of client income. A counselor may ask for documentation if he questions the client's statements; however, this is rarely done.

Pennsylvania has addressed this problem by requiring both verification of current income (such as a paycheck stub) and a copy of the clients most recent federal tax form 1040. The Pennsylvania Bureau of Vocational Rehabilitation indicated there has been an increase in client financial participation in the cost of the rehabilitation since this verification process was initiated.

The need for documentation is highlighted by DVR's reliance on client income at referral. Client income is reported only at the time of referral regardless of the individual's actual earnings over a longer time period. For example, in one case reviewed during this evaluation, the client quit working the day before application to DVR. On the intake form no income was shown which, although technically correct, did not reflect the client's economic position. This means that client income information, which is used by DVR in developing measures of program benefit, is of little value because it does not represent an accurate picture of client earnings over a longer period of time. Requiring the form 1040 or a Virginia income tax return would aid determination of financial eligibility and help develop more dependable data on long-term program benefits.

JLARC recommends that DVR require both a current income verification and a copy of the most recent 1040 or Virginia tax form as a check against fraud. The additional paper work is justified by the need to make certain that all clients that can participate financially in the cost of their rehabilitation, do so. The DVR program would also benefit because the total dollar resources available for handicapped clients would also be maximized.

The Use of Similar Benefits by DVR

Federal law requires that the availability of similar benefits be fully considered prior to the payment of public funds for client services. A similar benefit is any other source, either public or private, which may be available to support the cost of vocational rehabilitation. Pensions, insurance, workman's compensation, welfare, or public health services are examples of common sources of similar benefits. Full consideration must be given to using similar benefits except for evaluation, counseling, guidance, placement, and post-employment follow-up.[2] Similar benefits are to be used prior to the expenditure of vocational rehabilitation funds unless their use would significantly delay the provision of service or would interfere with the achievement of the rehabilitation objective of the client.

The purpose of the similar benefit provision in the 1973 Rehabilitation Act is:

> "to provide rehabilitation agencies with an organized method for assessing the eligibility of handicapped individuals for benefits under other programs and then drawing upon the other programs to provide rehabilitation services."[3]

The counselor is responsible for utilizing available similar benefits in all cases except where they would cause the client "discomfort or hardship" or would delay the provision of services. Counselors are expected to know what similar benefits are available and how to obtain them. In the report of the Second Institute on Rehabilitation Issues, the creativity of counselors in seeking out and developing similar benefit sources was cited as a primary means of "stretching the rehabilitation dollar."[4]

Counselors interviewed by JLARC indicated that prior to the FY 1976 budget moratorium, similar benefit sources were not used to any great extent.

This was partly due to generous vocational rehabilitation funding. Because there was sufficient federal money for both general rehabilitation programs and special programs, DVR counselors had not experienced a shortage in case service funds and had no incentive to seek out similar benefit sources.

Funding Variation. Some measure of the use of similar benefits by DVR can be gained by looking at the extent of DVR provided services which required full agency expenditure. As part of the federal reporting system, DVR specifies whether a third party (similar benefit) source supported all or part of the cost of a rehabilitation. Table 9 shows each major service and the distribution of cost responsibility for that service.

The table demonstrates the great variation in funding responsibility depending on the type of service provided. Four service options (restoration, college training, business school, and maintenance) were funded primarily by DVR. Since DVR financed 83.5% of all restoration services, it is clear that few DVR clients have health or hospitalization insurance. In addition, there is little evidence that Medicaid or other publicly supported health programs such as the State/Local Hospitalization Program of the Department of Welfare are used extensively. Since many DVR clients are public assistance recipients, it is reasonable to assume that some of them would qualify under one of the medical assistance programs.

The finding that almost 90% of all college training cases were fully funded by DVR raises a serious question whether the department used any of the several tuition assistance and scholarship programs which are available to the

Table 9

FUNDING RESPONSIBILITY FOR DVR SERVICES

Service	DVR Funded	Funded Through Another Source	Shared by DVR & Another Source	Number of Cases
diagnostics	53.4%	24.6%	22.0%	(8858)
restoration	83.5	10.7	5.8	(3507)
college training	89.7	5.3	5.0	(796)
business school	83.5	13.8	2.7	(254)
vocational school	57.7	38.0	4.3	(1340)
on-the-job training	25.2	73.2	1.6	(730)
work adjustment training	22.1	74.0	3.9	(2007)
maintenance	87.6	6.1	6.3	(1633)

Source: DVR Summary of Case Service Reports, FY 1975.

disadvantaged. Although the Basic Educational Opportunity Grant (BEOG) has been a widely used source of tuition assistance for students, DVR did not initiate a method of certifying that clients who received college training had applied for BEOG until January, 1976, when the Student Grant Assessment Form (VR-25) was distributed to counselors. There still is no means of assessing whether a DVR client is eligible or has applied for one of the State supported scholarship

programs such as the College Scholarship Assistance Program or the Tuition Assistance Grant and Loan Program, both of which are administered by the State Council of Higher Education.

A third source of similar benefits, not used to the maximum extent, is the NARC-OJT program. The National Association for Retarded Citizens (NARC) will provide on-the-job training funds to support retarded persons in job training situations. This support will subsidize 50% of the first 160 hours of training and 25% thereafter up to approximately 360 hours. DVR counselors who use NARC funds report it to be a valuable similar benefit source. Other counselors interviewed, however, were either unaware of NARC or did not use it. This finding was true of public school counselors who have mildly retarded clients and specialized counselors in the State's institutions for the retarded, as well as general counselors. Furthermore, the NARC field coordinator for Virginia has not noticed any increase in the use of NARC funds since DVR imposed its funding moratorium.[5] This indicates that knowledge about NARC resources is not communicated within DVR. This should be accomplished as rapidly as possible, particularly in light of the limited case service funds available.

Another method used to assess the extent to which DVR is using similar benefits was in an examination of all 48 cases in the JLARC survey which cost less than $100. Each case was examined to determine if use of similar benefits kept costs low. In only two of the 48 cases was there evidence that a similar benefit was used in place of DVR funds. In one case, workshop training was sponsored by a public school district; and in another case the client's hospitalization insurance was utilized.

DVR is currently moving toward the development of a more systematic and organized program of similar benefit determinations. Expanded written agreements with other agencies and documentation such as the Student Grant Assessment Form (VR-25) for BEOG eligibility are steps in this direction. However, an effective means of monitoring the use of similar benefits is not available. According to the policy manual, "it is the counselor's responsibility to determine if such (similar) resources are not available to a client. Prior to the use of DVR funds, the counselor must document that other resources are not available".[6] DVR does not collect information on the cost or value of similar benefits to rehabilitation; conduct studies of the use or need for similar benefit programs; maintain training programs for counselors regarding sources of many similar benefits; or have a routine means of cross-checking eligibility.[7] Without additional in-service training, the counselor cannot realistically be expected to fulfill the responsibility of certifying that a client is not eligible for other benefits. It is recommended that DVR develop an annual training program about similar benefit programs and utilization techniques.

VOCATIONAL REHABILITATION COSTS

The average cost of a successful rehabilitation which includes the cost of operating DVR was $2,275 in FY 1975. When expenditures for the client are considered alone, approximately one-quarter of the rehabilitations did not require any expenditure after the case was accepted for service. However, for those cases which did require expenditure, the average cost was $758 with 22 FY

1975 rehabilitations costing over $10,000. The cost of a case varies greatly depending on the disability involved, with severe physical handicaps and moderate to severe retardation the most expensive to rehabilitate. While the severely disabled generally cost more to rehabilitate than other clients, four categories of nonsevere disabilities were among the eight most expensive types of rehabilitations. The factor which accounts for the high cost of many rehabilitations is training.

Comparative Rehabilitation Costs

Total case service expenditures in FY 1975 were $12,226,425. Figure 3 shows how DVR spent these funds. The largest proportion was paid to the Woodrow Wilson Rehabilitation Center. Physical and mental restorations were the next largest type of expenditure followed by training expenditures.

As shown in Table 10, about two-thirds of all case service expenditures were made on behalf of cases which were eventually closed as rehabilitated. However, $2,236,987 was spent for cases which could not be successfully closed. The total in Table 10 of $9,045,487 represents the cumulative expenditures for all cases closed in FY 1975 although some of the expenditures may have occurred in other fiscal years.

Table 10

CASE SERVICE EXPENDITURES
FOR DVR CLOSURES - FY 1975

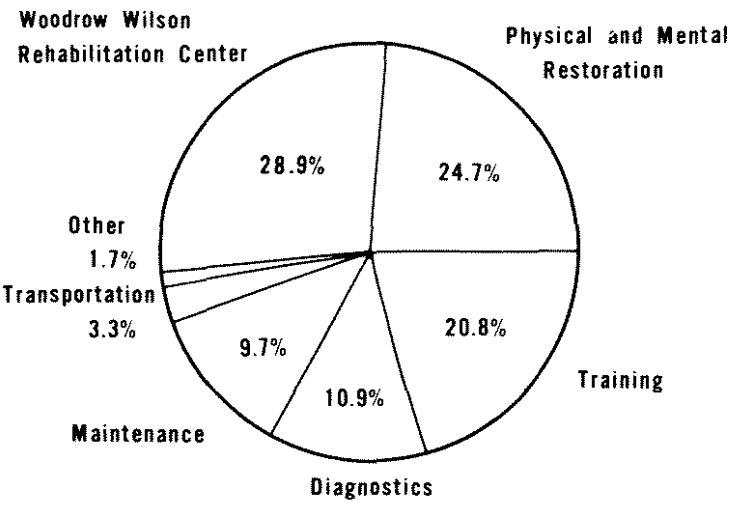
Type of Closure	Total Expenditure	Total Number	Number With Cost	Average Cost Per Closure (with cost)
Successful rehabilitation	$ 6,156,657	9,139	8,120	$758
Unsuccessful rehabilitation	2,236,987	4,745	3,795	589
Eligible but with only diagnostic services	53,822	567	406	133
Ineligible	598,021	18,771	5,153	116
Total	$ 9,045,487	33,222	17,474	$518

Source: DVR Summary of Case Service Reports, FY 1975.

In its annual reports, DVR cites "cost per rehabilitant" as being the average case service expenditure made for each case closed during a given fiscal year. For 1975, the average cost (if expenditure was required) was $758 while the average cost in 1974 was $639. However, these averages reflect only expenditures for case service (the value of services purchased for clients) and do not

Figure 3

DVR EXPENDITURES FOR CLIENT CASE SERVICES
(FY 1975)



Source: DVR Case Cost Report, June 1975.

include the total cost of the Department. In FY 1975, total DVR expenditure, excluding the Disability Determination Division, was $23,309,710. When all expenditures are considered, the average cost of a rehabilitation, other than a social security beneficiary, was $2,275. Comparative statistics which are available for all state agencies from the RSA show that DVR costs are $472 below the national average of $2,747 per case.[8] The RSA comparative statistics for FY 1975 should be viewed with some caution because of substantial reporting errors encountered in the presentation of the 1975 data. Nevertheless, DVR's cost per rehabilitation is in a low-average range nationwide.

A large number of cases closed by DVR are at no-cost. Of the 33,222 total eligible and ineligible closures in 1975, almost half did not require the expenditure of DVR funds. Of the eligible closures, 1,019 required no expenditure and were classified as successfully rehabilitated as shown in Table 11. Many other cases can be considered as essentially a "no-cost" rehabilitation. There were 2,286 rehabilitations costing $100 or less of which approximately 60% required an expenditure for diagnostic purposes only (generally medical or psychological exams costing between $13 and $50).[9] Since these cases do not require expenditure after acceptance as eligible clients, they can be considered as part of the no-cost rehabilitation category. Thus, about a quarter (2,400) or all FY 1975 successful rehabilitants did not require DVR expenditure for rehabilitation purposes.

Table 11

CASE COST FOR ACCEPTED CASES CLOSED IN FY 1975

Case Cost in Dollars	Cases Closed as Rehabilitated Number	Percent	Cases Closed as Not Rehabilitated (received services) Number	Percent
$0	1,019	11.2%	950	20.0%
$1-100	2,286	25.0	1,632	34.4
$101-600	3,091	33.8	1,312	27.7
$601-1,100	1,275	13.8	371	7.7
$1,101-5,000	1,290	14.2	415	8.8
$5,001-10,000	155	1.7	50	1.1
$10,001 +	23	.3	15	.3
Total	9,139	100.0%	4,745	100.0%

Source: JLARC analysis of DVR computerized records (RSA-300).

Cost Variation by Disability

The average cost of a rehabilitation varies greatly with the type of disability involved. Table 12 shows the average cost of the ten most expensive and the ten least expensive rehabilitations by disability category. It must be noted that based on the JLARC analysis the cost variance does not result from disabilities that are inherently expensive to serve, but rather from the result of providing similar services in the rehabilitation of similar kinds of disabilities. For example, allergy cases received expensive college training in almost two-thirds of all cases closed in FY 1975 at an average cost of $1,850 each. This concentration of an expensive service within a disability category increases the average cost for all similar cases. In contrast, clients with dental conditions rarely received high cost training services and, accordingly, are inexpensive on the average. The average cost of rehabilitation ranges from over $2,200 for severe orthopedic conditions to $300 for hypertension. If a secondary disability is identified, the cost of an average case is 16% higher than if only one disability was involved ($783 per case compared to $674 for all cases).

Rehabilitation Costs of the Severely Disabled

A major part of DVR's FY 1976 budget presentation to the Governor and the budget advisory committee was based on claims that the mandate to serve the severely disabled would be a more difficult and expensive mission to perform.[10] In the analysis of case cost, JLARC reviewed this claim and found it to be inconsistent. Based on direct costs, there are several important categories of the severely disabled that are relatively inexpensive to rehabilitate.

High Cost - Nonsevere Disabilities. No clear relationship exists between the severity of the disability and rehabilitation costs. In 1975, severely disabled clients cost an average of about $100 more per case than

Table 12

COST PER CASE FOR SELECTED
DISABILITIES REHABILITATED IN FY 1975

Disability	Cost Per Case	Number of Cases[1]
High Cost		
Orthopedic Impairment of Three or More Limbs[2]	$ 2,222	70
Nonsevere Speech Impairments	1,661	37
Spinal Cord Injured[2]	1,582	56
Hay Fever/Allergies	1,353	104
Epilepsy[2]	1,268	90
Ill-Defined Severe Disabilities[2]	1,264	19
Ill-Defined Orthopedic	1,244	287
Endocrine Disorders	1,157	47
Nonblind Visual Impairment[2]	1,121	40
Orthopedic Impairment of the Lower Limbs[2]	1,075	394
Low Cost		
Anemia and Blood Disease	644	12
Loss of One or Both Lower Limbs[2]	602	106
Benign Neoplasms	563	297
Personality Disorder	559	1,709
Mild Retardation	539	728
Psychosis[2]	528	333
Dental Conditions	454	280
Drug Addiction	454	191
Alcoholism	353	114
Hypertension	304	24

[1]Averages calculated only when DVR expended case service funds for a rehabilitation.
[2]Considered severely disabled.

Source: JLARC analysis of computerized DVR records (RSA-300), FY 1975.

nonsevere clients. However, four of the ten most expensive categories of disability listed in Table 12 involve handicaps not severe enough in and of themselves to be included in RSA guidelines identifying the severely disabled. While some of these may have met other criteria, probably half of the clients in the ten most expensive disabilities were not severely disabled.

Low Cost Emphasis on the Mentally Ill. Another major problem with the assertion that the severely disabled are expensive to rehabilitate occurs with DVR's commitment to serve the mentally ill. The mentally ill represent a large portion of DVR's severely disabled clients (27% in FY 1975). However, the mentally ill are relatively inexpensive to rehabilitate averaging $436 per case as compared to $674 for all cases in FY 1975. The difference in cost is even more striking when individual categories of mental illness are considered. Of

the 572 psychotic cases rehabilitated in 1975, 449 (78%) were severely disabled, yet the average cost for all psychotic cases was only $528. In addition, a third of all mental illness cases required no DVR expenditure at all.

The low cost of mental illness cases is due to the fact that many of these clients receive diagnostic service, psychiatric treatment, and some maintenance services from State supported institutions and clinics. The severe mentally ill clients are also unlikely to receive expensive kinds of training.

In FY 1977, DVR plans to fulfill the severely disabled mandate by emphasizing service to the deinstitutionalized mentally ill. Since most mentally ill cases are considered severely disabled and require lower case service expenditures, DVR should be able to increase service to the severely disabled without a commensurate reduction in case service funds for other disability groups. Also, DVR can serve a major portion of the severely disabled population without a major cost increase. As a result, the program decision to emphasize service to the severely disabled mentally ill is likely to minimize any negative budgetary impact of implementating the new federal mandates.

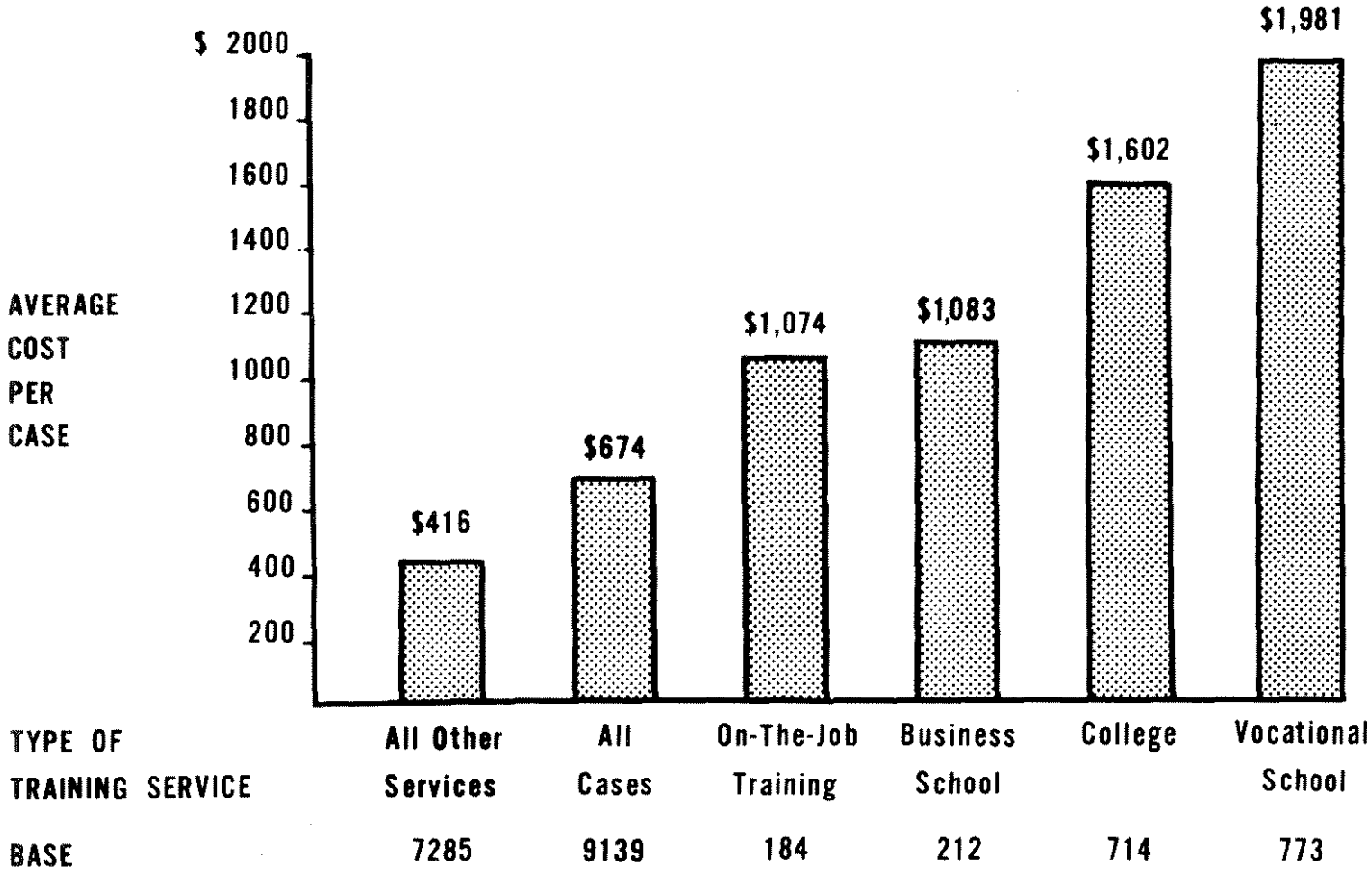
High Cost Service Options. The case analysis clearly shows that the high cost assumption of serving the severely disabled is overly simplistic. Instead, the findings show it is the nature of the service provided that determines the cost of the case. Certain service options, particularly vocational training, are expensive. DVR needs to reassess the distribution of services for handicapped clients and the way each affects the mandate to serve the severely disabled. Some limitations on the provision of expensive services to persons with less severe handicaps may be required so that funds will be available to provide the severely disabled with the services they require. DVR moved in this direction by limiting purchase of college training to the severely disabled for FY 1976; however, this limitation has since been removed.

Training is the key factor in increasing the cost of a rehabilitation. Cases which received no training cost an average of $416 while cases which received some training cost $1,497 per case. If the training received included payment for college, business, vocational school tuition, or for on-the-job training (OJT), the average cost of a case was $1,692. Specifically, cases in which the training was completely funded by DVR cost almost twice the average of all cases requiring full DVR expenditure. Figure 4 demonstrates how cost varies depending on the training received. Vocational training (post-secondary academic training, business or vocational school, and on-the-job training programs) is the single most costly option.

The high cost of training services is not only due to direct costs but also to indirect costs such as payments for maintenance while the student is in training. For example, if a client receives maintenance as well as college tuition, the cost of an average case increases from $1,602 to $2,684. Similarly, the costs of a vocational school case increases from $1,981 to $2,514 if maintenance costs are included. Significantly, two-thirds of all cases which received maintenance support also received vocational training as part of the rehabilitation. Since training costs constitute such an expensive service option for DVR, the agency would benefit from regular supervisors reviews of all rehabilitation plans which require long-term training programs.

Figure 4

COMPARATIVE REHABILITATION COSTS FOR DVR SPONSORED TRAINING



Note: Figures for sponsored training are based upon cases which required full DVR expenditure only - FY 1975

Source: JLARC Analysis of DVR Computerized Records (RSA-300).

SERVICE DELIVERY

Every client successfully rehabilitated by DVR must receive some service. The most basic set of services includes evaluation, counseling, guidance, and job placement. However, most cases require more extensive services including some mixture of restoration, training, maintenance, and a variety of supportive services. The two major service options used by counselors are restoration and training. Other services--maintenance, transportation, purchase of tools and clothing--are usually used to support the client during planned restoration or training.

Restoration is medical or medically related services which may, within a reasonable period of time, be expected to remove or substantially reduce the handicapping effects of a physical or mental condition.[11] Training services can be provided when a client has no saleable skills which, within the limits of the disability, can be used in satisfactory employment.[12] Training can be provided on two levels. Clients may receive personal adjustment training to develop their ability to function within a work environment (interpersonal skills, work habits, attitudes, etc.). Training at the adjustment level may also involve the development of skills relating to the use of artificial appliances, adjustment to physical loss or limitations, or remedial academic development. The other level of training is designed to prepare a client for employment through vocational or business schools, on-the-job training (OJT), or higher education at two year, four year, or graduate schools.

In analyzing the distribution of DVR services, JLARC found that the two major service options represent distinct and almost exclusive facets of vocational rehabilitation. Service overlap is minimal since clients who receive physical restoration services generally do not receive training while the opposite is true for clients that receive training. DVR provided restoration services to 3,507 rehabilitated clients in FY 1975, of which only 272 also received vocational training. If prevocational, miscellaneous, and adjustment training are included, the total number of restoration plus training cases was 490 or still only 14% of those clients who received restoration services. Therefore, each of the major service options can be analyzed independently.

Physical Restoration. DVR is most successful at physical restoration in which a client is provided with surgery, hospitalization, dental care, or a prothesis and then returns to work. Of these cases, 81% were successfully closed in FY 1975. Principal disabilities involved are dental conditions, hernias, benign tumors, genito-urinary disorders, digestive disorders, varicose veins, skin conditions, certain orthopedic impairments, and nonsevere hearing loss. There were 3,017 rehabilitants that received restoration but no training of any kind at a total cost of almost $2 million. Only 12.5% of these rehabilitants were severely disabled.

The physical restoration case requires only minimal counselor participation. Counselor interviews and case file reviews showed that preparation for a restoration case requires only routine paper work with little counseling or guidance. In addition, clients receiving only restoration services are five times more likely to have a job or work experience at referral than the average DVR client. Thus, job placement and follow-up are also generally not required. Because of the high likelihood of a successful closure and the minimal counselor

participation required, physical restoration cases are considered by counselors to be "easy" rehabilitations. For example, the following is a typical restoration case:

Case Number 3-9

> *A 21 year old male was declared eligible for service because of rectal bleeding and hemorrhoids. The client had a steady employment history as a general laborer but was forced to quit his job because of the medical condition. DVR paid $452 for corrective surgery, and the client was closed as rehabilitated with employment as a truck driver.*

Because of the high chance of success, the physical restoration case is also sought after by counselors as a means of fulfilling production quotas. DVR needs to ensure that service to this category of handicapped clients is not a result of efforts to meet production quotas, that each client satisfies all eligibility requirements, and that full use is made of other medical assistance programs for the medically indigent.

Training. Training services can involve either (1) prevocational training such as driver's training, prework adjustment, or remedial academic or (2) vocational training. In FY 1975, 4,245 rehabilitated clients (46% of all cases) received some type of training. Three-quarters of these clients were disabled by a mental or emotional disorder. Table 13 presents the number of successfully rehabilitated clients who received training services and demonstrates that training services are heavily concentrated in cases of mental disability. This emphasizes the dichotomy of DVR services--the mental cases receive training, while the physical restoration cases receive surgery.

Table 13

DISTRIBUTION OF TRAINING SERVICES FOR CASES CLOSED AS SUCCESSFULLY REHABILITATED - FY 1975

Training	Number of Clients	Percent with a Mental Disability	Rehabilitation Rate
Vocational Training			
vocational school	1,340	80%	56%
post-secondary academic training	796	40	69
on-the-job training	730	89	71
business school	254	68	64
Prevocational Training			
adjustment training	2,007	83	58
other academic training	618	91	61
miscellaneous training	681	78	54
All Cases	NA	77	60

Source: JLARC analysis of DVR computerized records (RSA-300), FY 1975.

Of the training options, the two most comparable are on-the-job training (OJT) and vocational school since the clients of each are so similar. Each has a heavy concentration of personality disorder and retarded clients--68% of the vocational school clients and 79% of the OJT clients. However, OJT appears to be much more effective since they have a high rehabilitation rate - 71% compared to 56% for the vocational school clients. This is probably due to the type of training that OJT provides, along with good work experience and placement efforts on the part of the counselor. DVR should expand use, where possible, of its OJT activities. This is particularly important due to DVR success in obtaining third-party financing of OJT training in contrast to vocational school which is primarily funded by DVR.

The high cost of using training as an option requires particularly careful caseload planning and management. During the course of this review, for example, it was found that DVR had provided expensive community college tuition, room, and board payment to several clients on probation or parole, all of whom were low priority behavior disorder cases. Several other expensive vocational training cases reviewed, raise serious questions about the way in which these cases are managed. For example:

Case Number 3-10

> *A 24 year old man sustained a back injury and was receiving workman's compensation. He had his benefits terminated after signing a release form in September, 1971, certifying that he could return to work. However, DVR paid $3,948 to the client for college tuition over the next two years.*

Case Number 3-11

> *A client was provided with $700 in college tuition despite a combined College Board Entrance Examination score of 600 (scores range from 400 to 1,600). The client was unable to finish the freshman year.*

Case Number 3-12

> *A client was provided with nine quarters of community college academic training at a cost of $538. The vocational goal was a clerical position. The client was closed as a cashier in a supermarket.*

Case Number 3-13

> *A 31 year old woman received $799 in secretarial training which the client reported was of poor quality and of no help in obtaining a job.*

Case Number 3-14

> *A 26 year old man working on the Metro System received $1,386 worth of heavy equipment operator training which was provided by a North Carolina vendor. No*

explanation was given in the case as to why an out-of-state vendor was used.

It is apparent from the case files that some counselors use vocational training to provide services to clients that are vocationally disadvantaged, either because they have no work history (school clients) or a limitation in their current employment. The problem with this approach is that there was often not a reasonable justification for either the choice of the training or the extent of the service. One case that carried this to an extreme was a client, disabled by drug addiction, who was initially provided with a complete undergraduate college program. When the counselor was informed that the baccalaureate degree was not marketable, DVR agreed to pay full tuition for a Master's degree program for the client. The cost of this case was over $10,000. JLARC recommends that the local supervisors review each case requiring extensive training so that unacceptable excesses do not occur.

Ancillary Services

In addition to the two major service options of restoration and training, DVR provides three types of ancillary services: maintenance, counseling and guidance, and placement. Approximately 1,900 clients completed a rehabilitation program in FY 1975 and received only these services. However, JLARC found that these cases rarely represent rehabilitations in which the client benefited significantly from DVR services.

Maintenance. Payments for maintenance, transportation, and the purchase of tools, clothing, and equipment for clients represent supportive services which are authorized at the counselor's discretion. Personality and emotional disorder cases are provided with maintenance at a rate higher than most, with 44% of all drug cases, 39% of all alcoholic cases, and 35% of all personality disorder cases receiving this service. Of all maintenance recipients, 81% were disabled by an emotional or mental disorder.

Maintenance is generally provided in conjunction with other rehabilitation services such as vocational training. However, clients referred from the State's correctional system often receive only maintenance services. In about 700 cases, DVR's rehabilitation effort consisted primarily of the purchase of clothing or tools for corrections clients. For example:

Case Number 3-15

> *A 21 year old client was accepted for service by DVR following his release from a Department of Corrections work camp. DVR purchased $130 worth of clothing for the client. One day later, the counselor found that the client was employed in construction, and the case was closed rehabilitated. The counselor provided no placement services and, based on the field notes in the case file, appeared to have had no counseling session.*

The 700 rehabilitations in this category cost $60,000 and, based on the files reviewed, clients did not significantly benefit from service. Cases receiving maintenance only are highly questionable rehabilitations since they

contribute heavily to the number of marginal cases claimed by DVR as having been successfully rehabilitated. In partial recognition of this, DVR has terminated its special corrections units. However, clients referred by Corrections remain eligible and will continue to be served by general caseload counselors. Based on the marginal nature of the "personality disorder" handicap and the minimal service usually provided to several hundred of these clients, it is recommended that DVR restrict and control acceptance of this type of client.

Counseling is a major service that DVR uses to justify its intervention in cases not requiring any purchased service. However, the subjective nature of counseling benefits make it nearly impossible to evaluate. It was clear that a wide range exists in the frequency of counselor-client contacts. The case files reviewed indicated that often there was not enough contact to show that intense or frequent counseling had occurred. Two client plans specified that extensive counseling was to be provided--but it was not. In the first case, a retarded client was to receive "extensive supportive counseling", but the notes document only two contacts over a three year period. In the second case, a client was to receive extensive counseling and guidance, but the counselor reported only one face-to-face contact and one phone call.

DVR has criticized previous reviews of the counseling component pointing to "little knowledge and understanding of the provision of counseling and guidance services in assisting the individual--particularly, where no other type of service is to be purchased by the counselor".[13] It is, however, unrealistic for any major and vital service to be exempt from evaluation. The problem that occurs in testing counseling is that there is no standardized way in which a counseling session is recorded. Field notes vary greatly in detail provided, and it is often not clear whether the counselor saw the client or simply received second-hand information regarding the client. Since counseling is considered to be a major service, DVR should evaluate counselor performance in this area. One approach to accomplish this purpose would be for DVR to develop a standard method to record a counseling session which includes such essential characteristics as purpose, duration, topics covered, and client reaction.

Placement. While evaluation of counseling is difficult because of its many intangible qualities, placement can be analyzed more readily. Placement is probably the single most important service offered by DVR since, without satisfactory placement in suitable employment, the other services provided a client are of marginal benefit. Responsibility for placing a client in employment rests with the counselor. Placement, traditionally, has not been a strong area of vocational rehabilitation. This was highlighted in the Second Institute on Rehabilitation Issues Report:

> *In addition to reasons for modifying the service delivery system in the area of placement, we should consider specific problems with the present system. For example, a problem frequently voiced by counselors is that they lack skills, such as job development, that are needed for effective placement. Several also argue that their professional parameters should not include placement activities because "counseling" is regarded more strictly as client oriented rather than community oriented.*[14]

The Institute report cites the problems associated with counselors untrained in placement and who are, therefore, intimidated by employers who may not be receptive to hiring the handicapped. The standard alternatives used by counselors involve the use of placement "specialists", the use of other job placement services such as the Virginia Employment Commission, or the preparation of the client to handle his own placement. These alternatives, however, do not relieve the counselor of the primary responsibility of placing each client who needs this service.

Analysis of the 120 case files found that DVR placement efforts were the weakest element in its service delivery system. Based on case file information, only 14 of the 120 (12%) rehabilitated clients obtained a job as a result of DVR efforts. For the remainder, the files revealed that the job placement needs of the client were assigned low priority by counselors. In most instances, counselors depend on the handicapped client to find their own job before closing the client as rehabilitated. For those clients who were in need of placement services (i.e., those that did not have a pre-existing job or a saleable skill), DVR failed in most cases to provide the most basic placement assistance which could reasonably be expected.

The weakness in the DVR placement system was further highlighted by the presence in the case file sample of a handful of examples of excellent placement work on the part of the DVR counselor. It was apparent from these examples that placement activities can have a beneficial impact if the counselor chooses to make this effort. A case representing what the reviewers feel is an acceptable level of placement activity is described below.

Case Number 3-16

> *A 38 year old woman disabled by total deafness had a work history as an industrial sewing machine operator. The client came to DVR in April, 1975, following a lay-off. The DVR counselor went to great lengths to find similar work. The placement effort included not only finding the client a job but arranging for the relocation of the client's trailer to minimize transportation problems. The client has remained employed as an industrial seamstress through September, 1975.*

This type of case was the exception, however, since many others documented the problems found in the job placement area. These problems are illustrated by the three following cases.

Case Number 3-17

> *A 16 year old client disabled by a "severe vocational dysfunction" with a history of mental illness, received food service training from DVR. This individual was a client for 20 months. In August, the counselor "talked with the client about placement in a place where she could adjust". In September, the counselor found out that the client was working and initiated closure. Ten days later the counselor found out that the client was again unemployed. Nothing was done for two months. In December,*

the counselor noted that the client was "not employed but is looking". The case was finally closed in late February after the counselor became aware that the client had found another job. In spite of the counselor's intention in August to assist the client in finding work, nothing was done on behalf of the client for 7 months.

Case Number 3-18

A 17 year old woman, disabled by blindness in one eye, received college training from DVR. She was a client of the Department for 4-1/2 years. Following graduation, she was sent a series of letters inquiring whether a job had been found. Eventually, DVR received a reply which stated in part "I did not let you (DVR) know of my employment earlier because I had been led to believe that your office would aid me in finding a job--After I arranged transportation to your office--I was told it was the job of the Virginia Employment Commission alone to help me to locate work. Perhaps you should update your letter (a letter sent by DVR offering the client help in finding a job) so that others will not be given false inferences."

Case Number 3-19

A 34 year old client, blind in one eye, was a client of DVR for three months. The client and counselor met once and the counselor gave the client two job leads, neither of which developed into employment. The client then notified the counselor that part time work was obtained as an assembler but that more permanent employment was required. Instead of initiating placement efforts, the counselor wrote a rehabilitation plan for the part-time job the client found on her own as an assembler. The case was closed as rehabilitated in less than the required 60 days. According to a JLARC follow-up conversation, the client has not been employed for several months and is still looking for a suitable full-time job.

Counselors were questioned during field interviews about the use of the Virginia Employment Commission (VEC) for job placement. Despite the obvious need for good relations between these two State agencies, DVR counselors were almost unanimous in stating that VEC services were of little benefit to their clients. Conversely, VEC counselors interviewed in the Richmond, Charlottesville, and Petersburg offices had numerous complaints about DVR including:

- DVR counselors do not care to make appointments for clients they are sending to VEC for placement services;
- Clients sent by DVR are often not "job ready" (trained and prepared for employment). This damages VEC's credibility with employers;
- DVR refers only the most difficult cases to VEC to place, but the DVR counselors place the easy ones;

- DVR clients are generally poorly or inappropriately trained;
- DVR counselors are not familiar with the job market, often training clients for nonexistent jobs;
- DVR counselors do not inform VEC counselors on the outcome of cases referred by VEC;
- DVR counselors do not share jobs for which DVR has no client with VEC, while VEC provides DVR with job lists;
- DVR counselors provide little information on clients they refer to VEC; and
- DVR counselors do not keep VEC informed of changing eligibility standards and priorities.

Clearly, communication and cooperation between DVR and VEC must be improved. According to VEC, the interagency relations were better several years ago when annual joint meetings were held (the last such meeting was in 1973). Now, however, counselors for both agencies complain about a lack of a free information exchange. A new cooperative agreement between DVR and VEC was signed in January, 1976, which hopefully will begin to correct many of these problems.

The fact that VEC apparently cannot find suitable job placement services for many handicapped DVR clients further emphasizes the need for adequate DVR job development efforts. The unique needs of many handicapped clients for specialized work, including job modification to meet the limitations imposed by the disability, should be provided by a counselor trained in vocational rehabilitation. Job development and placement should be an on-going process throughout the rehabilitation program and structured to meet the individual needs of the client. However, VEC should assist by routinely providing DVR counselors a listing of job openings. Nonetheless, job placement of the handicapped should not be relegated to another public agency.

DVR has taken one step which shows promise for improving its placement performance. Specialized counselors whose only responsibility is job development and placement have been used on an experimental basis in several DVR offices. Currently, the Alexandria office has a placement counselor and Richmond may sponsor a similar position in the near future. JLARC interviews with these counselors and their supervisors indicated that the specialized approach to placement offers substantial promise although there is not yet sufficient data to assess its outcome. While DVR intends to expand the number of placement counselors, the ultimate responsibility for a successful placement should remain with the general counselor. It is critical that they ensure all clients are "job ready" regardless of who assumes the responsibility for actual placement.

It is apparent that there is no statewide and general commitment on the part of counselors to active job development. Instead, job placement as practiced by DVR is essentially a passive activity relying heavily on each client to find employment. In many instances, counselors learn of the client's employment through friends and relatives, or through routine inquires about the client's job status. Although the rehabilitation profession sees "selective

and individualized" job placement as a principle which must remain basic to the rehabilitation program,[15] DVR does not currently maintain an effective placement program for its clients. JLARC recommends that DVR assign a high priority to training counselors in job development and placement techniques and require more active placement efforts for every client. Furthermore, DVR should consider assigning some of the counselors released from special units to job placement duties.

CONCLUSION

DVR administers a complex and often expensive service delivery system which has the capability of providing a wide range of client services. However, the planning process which guides the service delivery system has several weaknesses which often limit provision of appropriate and meaningful services. In addition, DVR counselors in the past have not been overly concerned with the conservation of State vocational rehabilitation funds due to the relative affluence of the program.

DVR provides two major services: physical restoration and vocational training. Few clients receive a comprehensive mixture of services which include both of these categories. Physical restoration (surgery, hospitalization, dental care, hearing aids, or prothesis) has a high successful rehabilitation rate but does not generally satisfy the mandate to serve the severely disabled client. Training is an expensive service option which is not managed in a uniform manner and which can lead to the provision of high cost and questionable training services if adequate supervisory controls are not exercised.

Job development and placement is the weakest element in DVR's service delivery system. Despite the major need for this service, counselors do not play an active role in the job seeking efforts of many of their clients. Instead, most DVR clients obtain their own jobs and then inform DVR that they are working so that the case can be closed as rehabilitated. There is a critical need for DVR to improve the training available to counselors in this area and to find ways to integrate the functions of the Virginia Employment Commission in the provision of placement services to handicapped DVR clients.

Overall, DVR has the capability to be of great benefit to the handicapped client. In most of the cases reviewed by JLARC, this benefit was apparent and the client enjoyed significant economic improvement as a result of DVR service. However, the number of cases which exhibited questionable or inappropriate casework activities suggest that there is not a workable internal review process which can ensure a uniform level of casework management. It is recommended that DVR increase the scope and impact of internal reviews through placing increased responsibility and authority for casework practices at the local supervisory level. Key factors which should be reviewed and critiqued by local supervisors include planning, the use of similar benefits, the use of vocational training, and counselor job development and placement efforts.

SHORT AND LONG TERM SERVICE IMPACT

This chapter assesses DVR's impact in rehabilitating the disabled both in the short term when the case is closed and then over a longer period. Overall, JLARC found that benefits claimed by DVR are overstated. JLARC reviewed 120 successfully closed cases and found roughly a third had not significantly benefited from DVR services. Public assistance recepients appeared to be an exception. About half those receiving public assistance at referral no longer received assistance at closure.

Long term impact is based on the results of a special employment follow-up study. Employment and income data were gathered for groups of clients for a period extending over two years from the time they were rehabilitated. Key groups included in the analysis were the severely disabled, clients served through special units, and a sample of the general client population. According to the follow-up findings, a large number of rehabilitants do remain employed, although at low income levels. A key exception appears to be those persons with a severe physical disability. The income for this group was found to be significantly higher than the average income.

A separate assessment of clients rehabilitated through special units showed no striking improvement among that group. The follow-up findings appeared to support the decision made by DVR to terminate the special units for correctional clients on grounds of insubstantial benefit.

IV. SHORT AND LONG TERM SERVICE IMPACT

A primary objective of vocational rehabilitation is the employment of disabled individuals. A traditional measure of program benefit has been not only the number of clients rehabilitated into wage-paying competitive employment, but also their income level. Statistics published by DVR indicate that the 9,139 clients successfully rehabilitated in FY 1975 appear to have benefited substantially. The percentage of all clients who had no earnings dropped from 85% at program acceptance to 18% at closure. The percentage of persons working for wages rose from 14% at acceptance to 77% at closure. Average earnings for these rehabilitants was $95 a week. In addition, 1,557 clients were closed as homemakers, 80 as unpaid family workers, and 201 as sheltered workshop employees.

SHORT TERM IMPACT

JLARC found that the impact of DVR on clients rehabilitated in FY 1975 is considerably overstated in the statistics published by the Department. One-third of the cases reviewed by JLARC did not appear to have benefited significantly as a result of being a DVR client. Where clients did benefit, about half received primarily medical or surgical services.

In assessing the nature of DVR's short term costs and benefits, JLARC considered three forms of measurement: changes in client income between acceptance and closure, an analysis of the reduction in dependence on public assistance, and an evaluation of the actual impact DVR had on its clients based on a review of sampled case files.

Changes in Income

The most direct way of measuring program impact is to compare the changes which occur in client income between acceptance and closure. In the case of vocational rehabilitation, this is not necessarily a dependable measure. Client income at referral is sometimes not accurately reported or does not reflect the client's actual earning potential. As noted in *An Evaluation of Policy-Related Rehabilitation Research*, "earnings at entry are biased because people seek the services of a rehabilitation agency when they are doing poorly". This bias is compounded by a lack of dependable recording of information at referral. Although federal regulations for reporting income at referral state that earnings are to be recorded for the week of referral, a number of examples were found where this may not have been done. In one case, the client quit work the day before he applied to DVR, thus his income was recorded as $0.

A second source of bias in the use of income comparisons, is that DVR accepts school and institutionalized clients who are obviously not working at referral. In FY 1975, over 40% of all DVR rehabilitants were in this category. Naturally, these clients report no earnings at referral and, therefore, show significant economic improvement on a statistical basis at closure. However, there is no comparable estimate of what employment would be without DVR intervention.

At issue then is DVR's claim of dramatic increases in client earnings between acceptance and closure. In DVR's *Biennial Report: 1974 and 1975*, earnings before rehabilitation for the two years totaled $9,535,760 and earnings after rehabilitation were given as $81,628,040 for an increase of over 750%. Since DVR's total expenditure for the two years was $49,000,000, it appears that the program has more than paid for itself in increased earnings for clients. This type of comparison is used by DVR to justify budgetary requests. Because of the biasing factors discussed earlier, this kind of presentation may considerably overstate program impact.

DVR should accurately assess the income changes which occur after a client has been in the rehabilitation program. An important distinction must be made, however, between clients who had an earning history prior to contact with DVR and the clients who were in school or in an institution and consequently were not employed. Better long term income information such as could be obtained by an IRS Form 1040 or a Virginia income tax return would also be valuable.

Public Assistance Reduction

An important benefit of maintaining a cooperative welfare-DVR program such as exists in Virginia's major urban areas is the elimination or reduction of welfare dependence through successful vocational rehabilitation. According to DVR records, in FY 1975, 979 rehabilitated clients received State supported welfare payments at referral (Aid to Families with Dependent Children (AFDC), General Assistance (GA), or a combination of both). At closure, over half were removed from the welfare roles at a net monthly reduction of $86,192 in welfare funds paid out to DVR clients. The annual reduction would project to about $1,035,000.

DVR also had some success in reducing the amount of welfare received by clients who were not completely removed from the welfare roles. Of the 979 welfare-DVR clients, 473 (48%) were still receiving welfare payments at closure, with most of these (406) remaining eligible for AFDC payments. JLARC found that the average monthly payment to clients who remained on welfare did show a slight decrease. At referral, each client received $160 per month on the average while at closure the average payment was $149 per month. This amounts to a monthly reduction in welfare dependency of $11 per client or about $63,000 annually. Thus, DVR services appear to have some effect on the economic well-being of welfare clients even though some are not removed completely from the welfare roles.

Overall, DVR did have success with clients that were welfare recipients at referral. While it is not known if these persons continue to remain free of dependence on welfare, one small follow-up study of rehabilitated welfare clients was conducted for DVR's Danville-Pittsylvania Welfare Project in 1975 and showed positive results. DVR should seek ways to generate more of this type of information through follow-up studies in conjunction with the Department of Welfare.

Impact of DVR Service on Clients Closed as Rehabilitated

In FY 1975, DVR claimed to have successfully rehabilitated 9,139 persons. In order to close a client as rehabilitated, federal law requires only that the client (1) was eligible, (2) received the appropriate services including

at least evaluation, counseling, and guidance, and (3) was employed in a suitable position for a period of 60 days prior to closure. But from a program perspective, there is an important question of whether DVR services significantly affect the client's employability. JLARC's review of 120 case files found that one-third of the clients did not significantly benefit from DVR services. In these cases there was little evidence that the client could not have achieved employment without DVR intervention. For example:

Case Number 4-1

> *A 58 year old man suffering from glaucoma was referred to DVR from a local welfare office. The counselor got the individual an eye exam and purchased a pair of glasses for him. The counselor then lost track of the client. A year later, the counselor found out the client was working as a career development counselor and closed the case as rehabilitated.*

Case Number 4-2

> *An 18 year old male was referred to DVR based on a history of drug addiction. DVR planned to put him in an on-the-job training program, but the client refused to participate. The counselor later learned that the client had found a job as a plumber's helper earning $90 a week and closed the case as rehabilitated. The counselor saw the client once.*

Case Number 4-3

> *A 15 year old male was accepted from a federal program for high school dropouts as a behavior disorder case. Although a client of DVR for over 2½ years, the counselor's case notes indicate that no actual contact between counselor and client took place and that the case was closed as rehabilitated after the counselor received a letter stating that the client had entered the military. DVR provided no training, spent only $23, and the counselor made no effort at placing the client in a job.*

Part of the reason that many cases such as these are closed as successfully rehabilitated is the counselor's need to satisfy a quota. Given the need to produce a set number of rehabilitations per year, the counselor can be expected to take credit for all possible successful closures. A supervisory review system (such as one recommended in a later section of this report) would require that the local supervisor assign a lower rating to a rehabilitation of marginal benefit to the client. This would serve two purposes. First, the number of such cases would be reduced. Second, counselors who serve more difficult cases would receive correspondingly more credit.

Part of the problem of low impact cases is the use of the highly subjective term "rehabilitation" for all cases which involve an employed client leaving the DVR system. Rehabilitation is an active term which suggests that a very positive change has occurred. Yet, as is true in any human service program,

not all clients accrue the same benefit from contact with the program. The use of a supervisory review which distinguishes between a rehabilitation and other employed closures could provide DVR with reliable information on program impact which is necessary for effective planning and management.

LONG TERM IMPACT

To assess the long term impact that DVR has, JLARC undertook a special follow-up study of clients successfully rehabilitated in FY 1974 and FY 1975. This review examined employment status to see how long successful rehabilitants remain employed and the level of income earned. The purpose was to evaluate the lasting effects DVR has on rehabilitants. However, this follow-up study is not meant to be definitive. Instead, it provides basic findings that should be used as one aspect of all the information necessary for making policy and management decisions. A summary of the follow-up methodology is presented on the next page and the Technical Appendix explains the methods employed in detail.

With employment as a criteria, the study examines persons employed in competitive positions. This excludes certain successful rehabilitants not holding this type of position such as farmers, housewives, the self-employed, and those working in sheltered workshops. Additionally, it was found that a large group of those that were employed were not reported on the VEC Wage File. This group was made up of local government workers, military employees, laborers, maids, and others. Together they represented 43% of the entire sample. However, the follow-up findings are statistically representative of clients closed in positions covered by VEC wage records.

The General Client Population

The follow-up study found a steady drop-off in employment for the first nine to twelve months after a client is reported as rehabilitated. Approximately half of the clients with earnings reported at closure failed to remain employed during this initial period. Figure 5 shows the rate of employment for all clients in the general sample. Of the 57% that are reported to have earnings when rehabilitated, the level of employment continuously declines to about 30% after twelve months. After this period, the rate of continuous employment remains steady.

The study did reflect some unexplained increase among those who had been closed the earliest -- the first three months of FY 1974. More of these clients remain employed after a period of 24 months than for those rehabilitated even a shorter time.

Annual Attrition. After the initial attrition of approximately one-half of the clients with earnings reported in FY 1975, the balance had remained continuously employed to October, 1975. To determine net attrition, JLARC added to this group: clients that failed to stay employed initially but subsequently found other competitive employment so that their wages were reported; and clients that did not appear initially as competitively employed, but who were employed by the final three months for which earnings are reported. By including clients re-employed, net employment within one year of being successfully closed was found

EMPLOYMENT FOLLOW-UP METHODOLOGY

Three samples were drawn for the follow-up. The first sample represented the general client population served by DVR in two years, fiscal 1974 and fiscal 1975. Included in this set were clients closed successfully as well as those who were declared eligible but were closed unsuccessfully. A second sample of clients covered the severely disabled. A third sample represented clients served by the special units.

Except for the special unit sample, clients were selected randomly by computer from a master tape provided JLARC by DVR of all closures for fiscal years 1974 and 1975. In the case of the special unit sample, clients were randomly picked by hand. Data on each client selected was then matched with wage information available to JLARC from the Virginia Employment Commission. A wage-record file maintained by the VEC on everyone in the State that pays Unemployment Insurance was used as the source for the wage information. This file covers roughly 80% of all those employed in the State. Major groups not covered on the file include such categories as farm laborers, the self-employed, some construction workers, public school employees and city employees.

The wage information is maintained quarterly for the most recent five quarters. For this study, the period covered included the third quarter of 1974 through the third quarter of 1975. (See chart below.) By necessity, the type of wage information available restricted the study to those employed in competitive positions. Precautions were taken throughout the process to preserve client confidentiality. For a more detailed description of the methodology used, see the Technical Appendix.

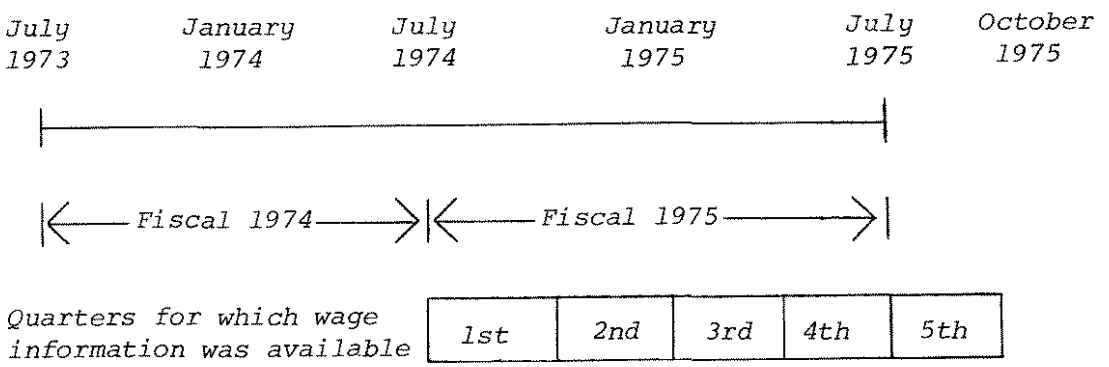
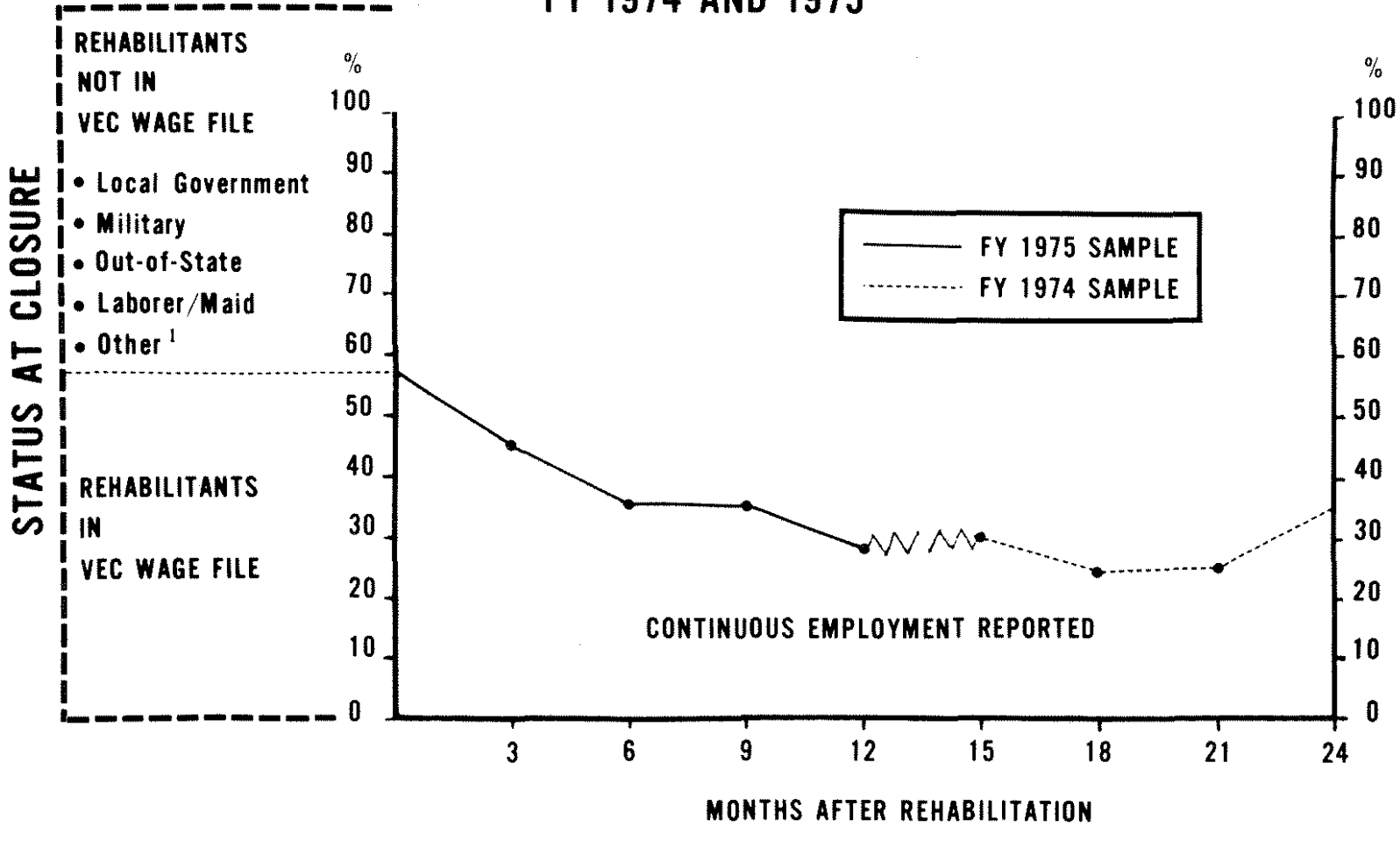


Figure 5

EMPLOYMENT LEVELS OF SUCCESSFUL REHABILITANTS FY 1974 AND 1975



1. Includes 8 rehabilitants on VEC wage file, but not at reported closure date.

Source: JLARC Employment Follow-Up Study

to be 47%, or just 10% below the known level at the time of closure. Employment a year later shows a similar drop-off of another nine percentage points. Thus, net attrition is 19% or one-third of those found initially employed in jobs covered by the VEC wage file.

The fact that half of DVR's rehabilitants who were reported as competitively employed initially do not remain employed after one year is a significant drop not simply explained. While some will take jobs not covered by the wage file, they will be offset by others not covered initially but who show up later as employed. Whether this attrition is due to an inherent weakness of the rehabilitation process in general or due to some specific aspect such as poor placement is not known. The following section examines several aspects of this attrition among different client groups. The analysis is focused on just those with earnings reported by VEC at closure.

Differences by disability were found for those that remained steadily employed. Persons with physical disabilities, particularly general medical conditions, are most likely to stay continuously employed. This is in contrast to clients with mental disabilities where continuous employment was not found to be as high. Heaviest attrition is seen among those classified as having a behavior disorder, drug addiction, or alcoholism. This could be predicted since a previous JLARC report - Virginia's Drug Abuse Control Programs - found very little employment impact in treating drug addiction cases.

Figure 6 illustrates the levels of employment for the five prevailing service patterns described earlier. The average level of continuous employment for all disabilities combined for the FY 1975 rehabilitants was 60%. This varied from a high of 89% for clients with general medical conditions to a low of 42% for the Behavior Disorder - Drug Addiction - Alcoholism disabilities.

Level of income was another measure used to assess whether DVR has enabled their clients to become economically independent. Table 14 points out the average earnings for successful rehabilitants for each of the two fiscal years studied. While it is obvious that clients remaining steadily employed have higher incomes than those who dropped out, income even among the steadily employed is low--averaging $4,600 to $6,000 annually.

Table 14

ESTIMATED ANNUAL INCOME FOR SUCCESSFUL REHABILITANTS
FY 1974 and 1975

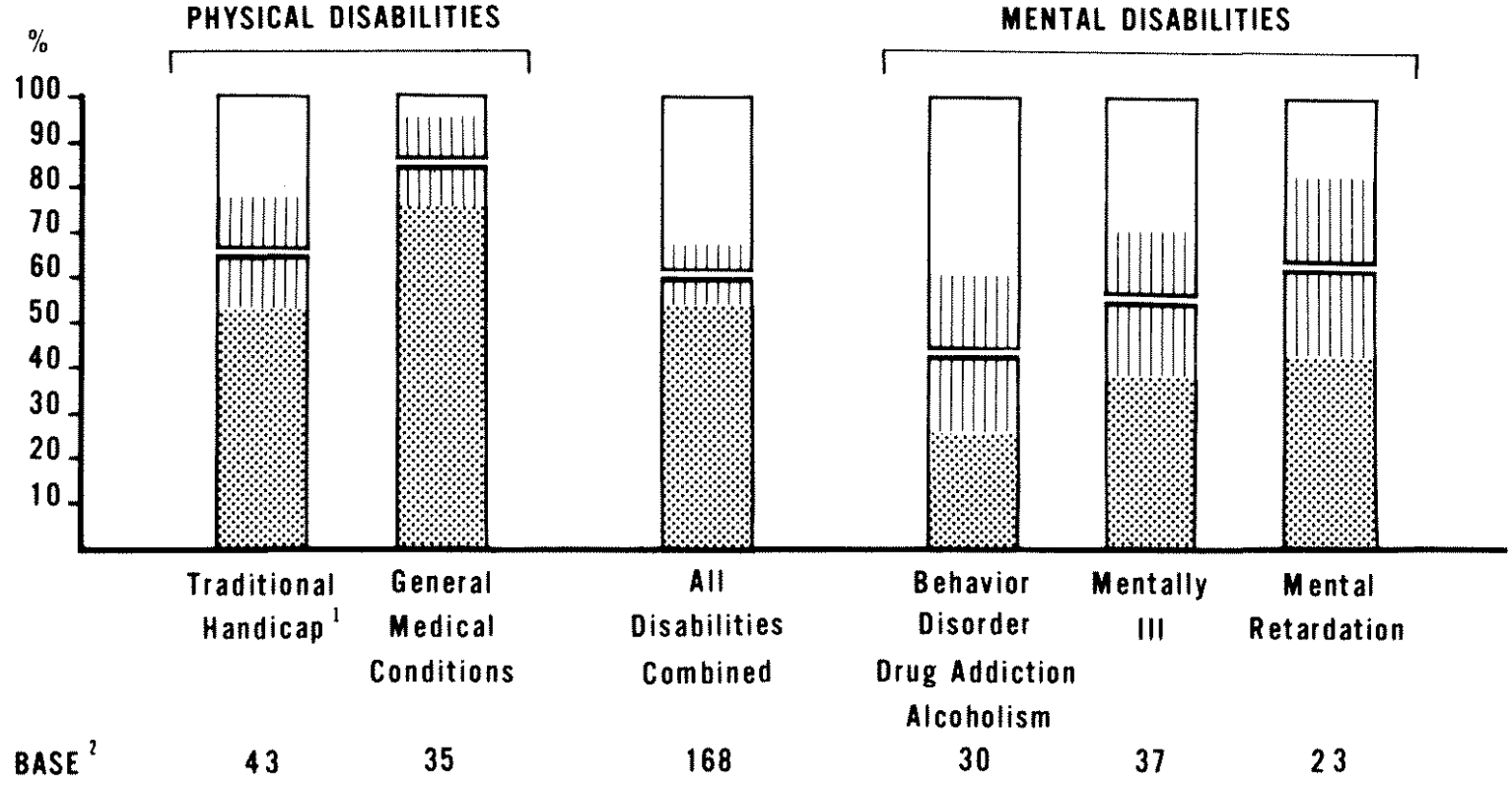
	Clients With:	
	Employment Not Continuous Since Closure	Continuous Employment Since Closure
FY 1974	$2,600	$6,000
FY 1975	2,700	4,600

Note: Estimate based on 4 times average quarterly earnings.

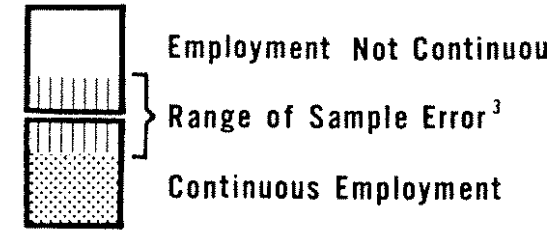
Source: JLARC Employment Follow-up Study.

Figure 6

EMPLOYMENT LEVELS OF SUCCESSFUL REHABILITANTS FY 1975



1. Visual, hearing, or limb impairment disabilities.
2. Only those with earnings reported at closure
3. The levels of employment reported will not exceed the ranges indicated more than once if this study were repeated 20 times.



Source: JLARC Employment Follow-Up Study

Clients rehabilitated in FY 1974 earn more than those closed in FY 1975, and two factors probably account for this. First, clients making the least money are probably the ones most likely to leave their jobs. Thus, average income for individuals who stay employed is likely to be higher since low wage earners are eliminated. Secondly, clients closed in FY 1974 have remained employed longer and would be more likely to have received pay increases. These factors, rather than the possibility that DVR was better rehabilitating clients in 1974, are likely to explain the difference in income between clients closed in the two years.

Regardless of the income difference, the fact remains that earnings for both years are low. In examining client income, it was found that most rehabilitants earn $6,000 or less (Table 15). At this income level, it is difficult for many clients to reach any semblance of economic independence. More importantly, a substantial number of DVR's rehabilitants are at or below the U. S. Department of Labor's poverty level of $5,500 for a family of four. Even the level set for unmarried people--$2,800--is not reached by many rehabilitants.

Table 15

ESTIMATED ANNUAL INCOME--CLIENTS STEADILY EMPLOYED

Clients With Income Not Greater Than:	Year of Closure FY 1974	FY 1975
$2,000 or under	10%	12%
4,000	30	40
6,000	48	82
8,000	82	93
10,000	93	98
12,000	99	99
14,000	100	99
16,000	--	100
16,000 and over	--	--
Base:	(58)	(100)

Source: JLARC Employment Follow-up Study.

There was little evidence found that the low income characteristic was improving. JLARC determined if incomes of clients rehabilitated in FY 1975 who remained steadily employed had experienced growth since being closed. While some had experienced income growth, just as many experienced a decline (52% earned more in the last three months than the average for all months since closure, but 48% earned less).

Some clients do achieve higher incomes. However, the 7% who earned $8,000 or more in FY 1975 revealed few similarities that would suggest DVR has more success with either one type of client or one type of disability. A key factor common to this group is the fact that half were working at referral. Others had earnings in one or more quarters prior to being closed. This implies that many clients either were not seriously disabled or else had good job skills and had already established a work history prior to DVR assistance.

There is no additional significant characteristic that explains higher income. These clients were different in age, marital status, and race. Education did not appear to be a contributing factor. Clients did not have similar disabilities, but they were found to have both serious and minor physical and mental disabilities. DVR's involvement in some cases was substantial; in others minimal, sometimes with little or no expenditure. There was no consistent evidence that clients who earned the most could attribute their success to DVR. Beyond this, there was evidence that many had existing job skills and were already employed at referral with only a minor disability.

The Severely Disabled

A significant portion of DVR's rehabilitants have minimal disabilities and a disproportionately large number of clients who remain steadily employed receive physical restorations and nothing else. Therefore, the question needs to be raised as to how well the agency does in rehabilitating individuals with severe disabilities. In order to examine DVR's performance in rehabilitating this type of individual versus others less severe, JLARC developed special samples for each. The comparisons use clients rehabilitated in FY 1975. Three categories of the severely disabled were examined; the physically disabled, the mentally ill, and the mentally retarded. An additional sample of clients with a severe physical disability, but who were rehabilitated a year earlier in FY 1974, was also drawn for comparative purposes. (Identification problems limited this comparison to only clients with physical disabilities.) The results for these three groups follows.

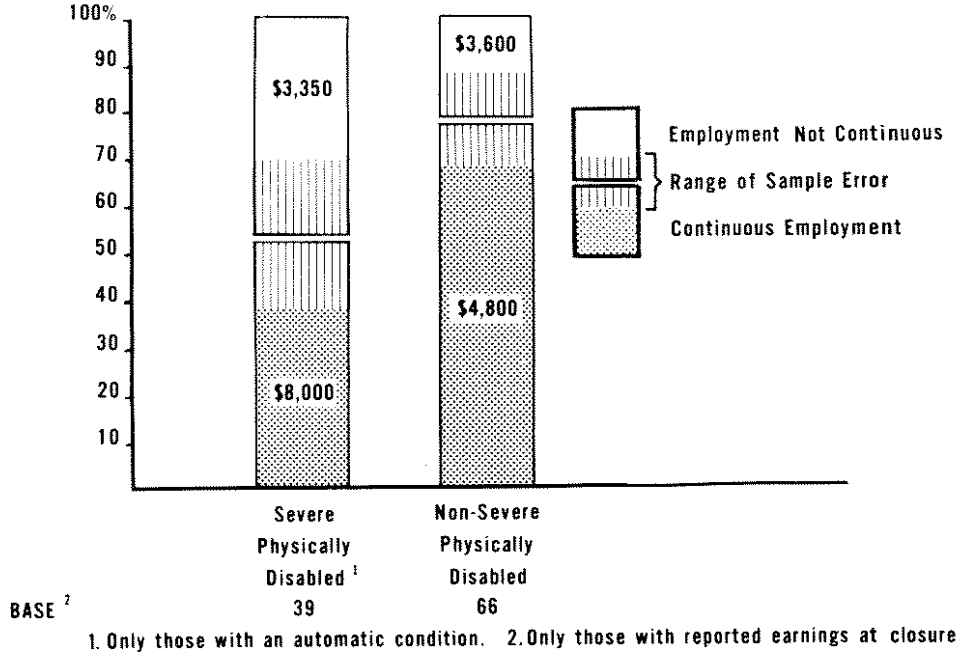
Severely physically disabled clients remain steadily employed in substantial numbers. Half of these clients with earnings reported had continuous employment. Even though earnings were significantly lower for clients with less severe physical conditions, the fact that so many stay continuously employed is encouraging. Figure 7 shows the average levels of employment for the severe and nonsevere physically disabled. Also reported are the average income levels for those staying continuously employed and for those not continuously employed. It is significant that the average income level of the severe physically disabled is well above that found for DVR's population as a whole.

At $8,000, earnings for clients with severe physical disabilities who remained steadily employed were $2,000 to $3,000 higher than for the nonseverely disabled clients. This may be due to more effort in rehabilitating and placing the severely handicapped. For example, they are likely to receive more intensive services from the Woodrow Wilson Rehabilitation Center. Furthermore, the severely disabled once employed, are more likely to be motivated to keep jobs than the more job mobile client. Many of the clients with nonsevere conditions, particularly those receiving surgery for a temporary general medical condition, are able to return quickly to the same low paying job, which was previously held. Whether or not these factors account for the income difference, the fact remains that one important segment of the disabled population served by DVR can earn a liveable wage--the severe physically disabled.

In comparing the FY 1975 severe physically disabled clients with those closed a year earlier in FY 1974, it was found that lower levels of employment and lower incomes prevail for the 1974 group. Those that remained steadily employed from this earlier year, earned an average of $5,600 a year. Though

Figure 7

EMPLOYMENT AND INCOME LEVELS FOR THE
PHYSICALLY DISABLED REHABILITATED IN FY 1975



1. Only those with an automatic condition. 2. Only those with reported earnings at closure.

Source: JLARC Employment Follow-Up Study.

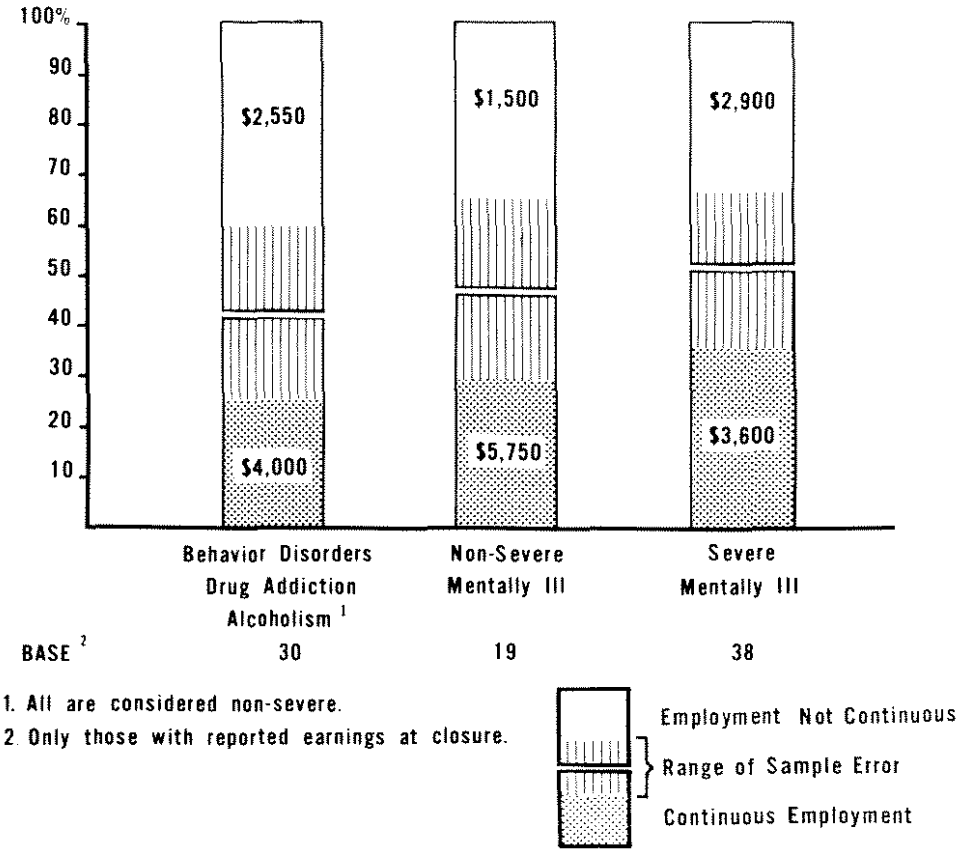
lower than that earned by those closed in FY 1975, this level was at least comparable to the level found for all rehabilitants closed in FY 1974. Based on these findings, it is reasonable to assume that DVR can expect to achieve favorable rehabilitation results by redirecting its effort to seek out and serve clients with severe physical disabilities.

The severe mentally ill were compared several ways--with personality disorder (including drug and alcohol cases) and nonsevere mentally ill clients. Mental illness as defined by DVR occurs in two ways--psychosis and psychoneurosis. The factors that usually result in classification as severe is that the individual has been institutionalized and is on medication.

As shown in Figure 8, the findings for these three groups of the mentally ill are not generally as favorable as for the physically disabled. Fewer individuals remain employed and even when they are employed they tend to have lower earnings. Approximately half of each of the three groups stay employed. But unlike those with a physical condition, the severe mentally ill earn less than those with less severe mental conditions. In fact, the severe mentally ill had among the lowest average income of any one disability group that was continuously employed. Of the two nonsevere client groups examined, incomes for the nonsevere mentally ill averages almost $2,000 a year higher than the personality disorder cases.

Figure 8

EMPLOYMENT AND INCOME LEVELS FOR
MENTALLY ILL REHABILITANTS
FY 1975

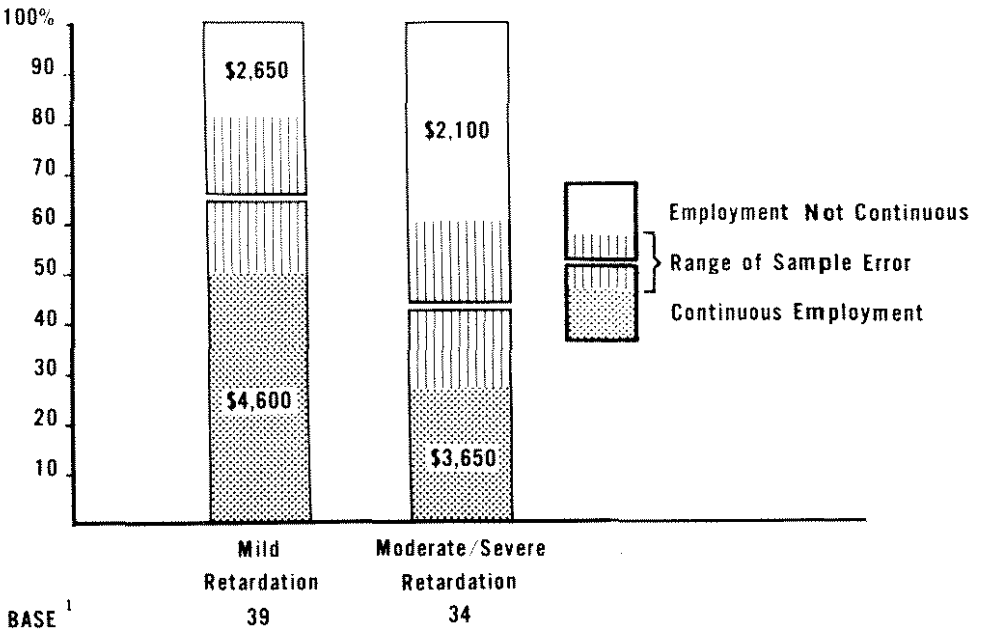


Source: JLARC Employment Follow-Up Study.

The mentally retarded are categorized by RSA in three distinct groups - mild, moderate, and severe retardation. Both moderate and severe retardation are considered a severe disability under federal regulation and have been combined for purposes of this analysis. As seen in Figure 9, employment among the severe group was far lower than for the mildly retarded. In fact, the mildly retarded were found to have one of the highest levels of employment of any disabled group served by DVR. This may be the result of this group's being easier trained than others. Further, many individuals in this group are capable of obtaining or holding a job on their own. An example of a mildly retarded school client in which DVR's role is indirect is cited below:

Figure 9

EMPLOYMENT AND INCOME LEVELS FOR RETARDED CLIENTS
FY 1975



1. Only those with reported earnings at closure.

Source: JLARC Employment Follow-Up Study.

Case Number 4-4

> *A 15 year old boy with an IQ of 72 was referred to DVR by a local school. The school provided most of his training. The counselor did little but follow the case. The case was closed when the boy took a job working for his brother in a construction business making $80 a week. Through a phone conversation with the boy, JLARC determined that he was still working but for another firm.*

The severely disabled retarded, remaining continuously employed, have low earnings ($3,650) which is at least above the poverty line of $2,800 set for single adults. This is comparable since retarded clients are rarely married. Further, most retarded clients are closed in sheltered workshops and, accordingly, were not included as part of JLARC's review. With this support, many of these individuals would be able to achieve a stable pattern of living compatible with their abilities.

Conclusion. Employment levels for the severely disabled were the same or lower generally than that found for disabilities that are nonsevere.

Nonetheless, a substantial number of the severely disabled--physically or mentally--remain steadily employed. In fact, the severe physically disabled appear to be one of the few groups served by DVR that earn a liveable wage.

Employment Follow-Up for Clients Served in Special Units

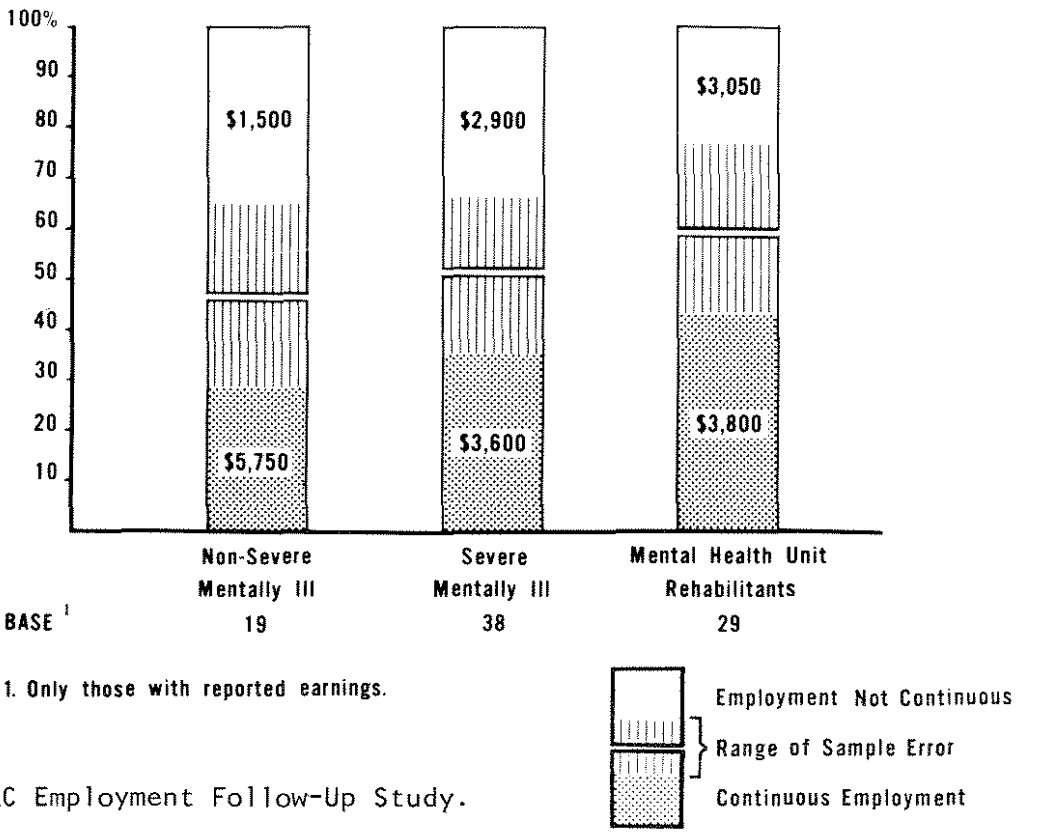
A special commitment of DVR has been serving selected clients through the development of special units. Four units examined as part of this follow-up are: Mental Health, Corrections, Welfare, and schools. These units are generally the result of federal efforts to broaden the role of vocational rehabilitation. They were created as the result of special federal financial grants or expanded eligibility guidelines. The total investment in these special units of $3.7 million warrants special review.

Mental Health Units have been established by DVR to provide vocational rehabilitation services at the four State mental hospitals, the Lynchburg Training Center, and the Northern Virginia Mental Institute. Counselors of DVR often work closely with staffs of these institutions in a team approach.

The rehabilitation efforts of the Mental Health Units is compared to the severe and nonsevere mentally ill. As seen in Figure 10, the outcomes for clients served by a mental health unit in terms of employment and income resemble

Figure 10

EMPLOYMENT AND INCOME LEVELS FOR MENTALLY DISABLED CLIENTS
FY 1975



Source: JLARC Employment Follow-Up Study.

those of the general category of severe mentally ill. This is expected since anyone with a history of being institutionalized in a mental hospital can be classed as severely disabled. Furthermore, many clients classed as severely disabled were likely to have been rehabilitated through one of these special units. This may account for the fact that there is little difference between these two groups, and not necessarily to the fact that special unit mental health counselors may be having more impact than regular field unit counselors.

School Units. Eight school districts across the State are served by DVR counselors. Other school districts can refer clients to their nearest field office, but only these eight have a vocational rehabilitation program set up under DVR control. The agency has been reviewing the possibility of discontinuing these units. Furthermore, a new State Education Law requires that local school divisions provide special education for handicapped children through age 21. The eight units served by DVR differ from one another (one serves mostly retarded students while the balance serve a mixture of disabilities). On an overall basis, two basic groups of disabled are served here--the retarded and those with behavior disorders. The latter are often students who are truants or who otherwise are presenting a behavior problem in school.

The results of the employment follow-up for rehabilitants served through the school units were generally comparable to those for all rehabilitants. As shown in Table 16, employment levels are generally the same since approximately half of the school clients with earnings reported remain steadily employed.

Table 16

EMPLOYMENT AND INCOME LEVELS - SCHOOL CLIENTS

	Level of Employment[a]	Average Earnings
Continuous Earnings Reported Since Closure	54%	$4,400
Earnings Ceased Since Closure	46	2,400
Base:	(72)	(72)

[a]Due to sampling variations, figures may deviate by as much as 12% above or below the values shown.

Source: JLARC Employment Follow-up Study.

Earnings were also comparable--$4,400 annually for school rehabilitants versus $4,600 for all rehabilitants. Thus, employment for school unit rehabilitants is not any better or worse than all disabilities served.

Welfare Units. Emphasis at the federal level has extended vocational rehabilitation services to public assistance recipients in approximately a dozen welfare offices around the State. Incentive for this investment was created by allowing the cost for these units to be paid with 90% federal money, and 10% State general funds, rather than the usual 80%-20% formula.

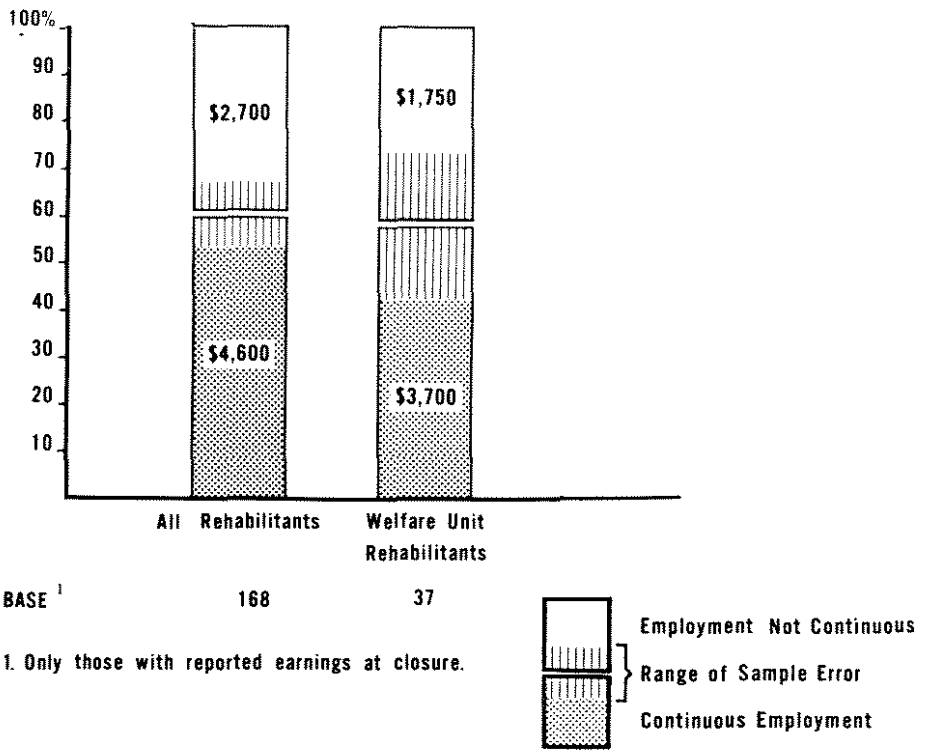
Of any group studied, those rehabilitated through a welfare office approximates the level of employment found for all rehabilitants. This should be expected since the welfare unit counselors serve a broad cross section of disabilities. Figure 11 shows that average income for the welfare client is generally lower than for all rehabilitants.

Table 17 contrasts the welfare status of sampled public assistance recipients at referral and later when they were closed. As shown, many clients closed as successfully rehabilitated continue to receive public assistance. Overall, there is a reduction of about 36%--from 68% to 32%. This generally compares to the 52% total reduction reported by DVR for all welfare recipients. However, the low incomes suggest that DVR's impact in reducing welfare dependence may be transitory since incomes are at or near the poverty level. More emphasis will have to be placed on this group if it is considered a priority in the future.

Correctional Units. Special DVR units located at the four State correctional facilities were the Beaumont School for Boys, Bon Air School for Girls, Natural Bridge, and Southampton. In addition, there were DVR counselors located in the Federal Reformatory in Petersburg and the Chesapeake Jail. These units were appropriately terminated in FY 1976 since the clients served generally had low priority behavior disorder disabilities (nine out of every ten cases seen were in this category).

Figure 11

EMPLOYMENT AND INCOME LEVELS FOR CLIENTS
REHABILITATED BY WELFARE UNITS



Source: JLARC Employment Follow-Up Study.

Table 17

WELFARE STATUS OF CLIENTS REHABILITATED THROUGH WELFARE UNITS

	Status at Time of Referral %	Status at Time of Closure %
Receiving Public Assistance	68	32
Not Receiving Public Assistance	32	66
Not Available	--	2
Base:	(37)	(37)

Source: JLARC Employment Follow-up Study.

The level of employment found for any client rehabilitated through the six correctional facilities was one of the lowest of any group examined. Employment levels compared only to behavior disorders, drug addicts, and alcoholic cases combined. Furthermore, earnings for correctional unit clients who stayed continuously employed, as shown in Table 18, was only $2,300. This reflects not only the difficulty in rehabilitating this type of client but also the fact that often counselors only provide minimal services for these clients. Thus, this is the lowest income for any group reviewed. Corrections rehabilitants (most of them young, white, single, males) constitute the largest segment of rehabilitants that fail to stay employed. The DVR decision to terminate these units appears to be justified in terms of client benefit as well as the severity of the disabilities involved. Table 18 shows the follow-up results for the corrections rehabilitants.

Table 18

SUCCESSFUL REHABILITANTS SERVED BY A CORRECTIONS UNIT

	Level of Employment[a]	Average Earnings
Continuous Earnings Reported Since Closure	44%	$2,300
Earnings Ceased Since Closure	56%	$1,950
Base:	(46)	(46)

[a]Due to sampling variations, figures may deviate by as much as 14% above or below the values shown.

Source: JLARC Employment Follow-Up Study.

Summary. With the exception of correctional units, there are no striking differences in the levels of employment found among the different special unit clients. Similarly, there is no significant difference in the levels of employment between special unit clients and those rehabilitated through a general field unit. However, the low incomes of correctional and welfare unit clients indicate that these units may not be having the long term impact intended. Similarly, the low employment levels among correctional unit clients tends to confirm DVR assessment of client benefit from these units.

Employment Follow-up for Clients Closed Unsuccessful

Not everyone who becomes a DVR client is successfully rehabilitated. Some drop out before completing the rehabilitation process. To determine if those who drop out after receiving only some services benefit from their partial contact, separate samples of the unsuccessful rehabilitants were drawn. Two categories of unsuccessful rehabilitants are examined - those who received at least some services and those that received none.

In contrasting the follow-up results for these two groups against those closed as successfully rehabilitated, employment has been viewed somewhat differently than before. Someone closed as unrehabilitated would not necessarily be expected to be employed in the quarter he was closed. Thus, employment was looked at in terms of employment in the quarter closed or any quarter thereafter and not in terms of consecutive quarters worked from closure as done previously.

Table 19 compares the results of those who were closed unsuccessfully having received some vocational rehabilitation services with those successfully rehabilitated. As seen in the table, only 21% of those who fail to complete the rehabilitation process had any reported earnings after their case was closed. The comparable figure for those who did complete the rehabilitation process was much higher, 69%. Furthermore, earnings for those who dropped out were quite low in comparison to those who were rehabilitated - $1,450 versus $2,600 for each respectively. Analysis of the clients that dropped out revealed that only 6% stay employed after earnings were first reported. These individuals, however, made much more, averaging $3,900.

Table 19

EMPLOYMENT AND INCOME LEVELS SUCCESSFUL AND UNSUCCESSFUL REHABILITANTS

	Closed Successful	Closed Unsuccessful
Earnings Reported at Close or Anytime Thereafter	69%	21%
Average Amount Earned	$2,600	$1,450
Base:	(289)	(250)

Source: JLARC Employment Follow-up Study.

Clients who drop out before receiving any services also evidence low levels of employment, though not as low as those who received services. Thirty-six percent of those not receiving any services before being closed as unrehabilitated had any subsequent earnings. And these individuals only made an average of $1,800. Of those that continued to work--12%--there were higher incomes reported, averaging $5,000.

The fact that this group did somewhat better than clients who received some services cannot be explained. There are numerous differences between the two groups that prevent any conclusions from being drawn. For example, most of those who received some services were under age 20 and thus may be less employable. Since few that fail in their rehabilitation stay employed, there is a serious question over whether the large amount of money spent on drop-outs had much impact. A total of $2,236,987 was spent in case service funds for over 4,000 clients who were closed unsuccessfully in FY 1975. JLARC reviewed a few cases that were closed as unsuccessful and found examples of cases that were carried for years without any obvious benefit to the client.

For example:

Case Number 4-5

> *A 17 year old girl who blinded herself in one eye at the age of seven was first seen in February, 1969. DVR paid over $3,000 for training over a six-year period--(business school and then nursing). The girl never did work full-time and was finally closed as unrehabilitated when she refused to go to work.*

This case probably should have been closed as unrehabilitated in November, 1972, when the client first dropped out of business school.

It is evident that if a counselor can successfully rehabilitate a client, the client will achieve measurable benefits over those closed unsuccessfully. Some residual benefits are seen among those closed unsuccessfully, but since those not receiving services appear to do better than those that did receive some services, this benefit is minimal. A stronger supervisory review is necessary over cases that counselors continue to carry for a long time to prevent unnecessary funds from being spent. It is recognized, however, that DVR must accept difficult cases and that not all will be closed successfully.

Summary and Conclusion

Program benefits claimed by DVR are overstated. Although the agency reports a 750% increase in client earnings between referral and closure, the fact that fully 40% of all FY 1975 rehabilitants were in school or institutionalized at referral makes this type of comparison of little value. Furthermore, client incomes at referral are not a reliable measure of a client's earning potential. JLARC recommends that earnings data clearly differentiate between those clients who were previously employed and those clients who, because of school or institutionalization, could not have had an income at referral.

JLARC found that one priority group - disabled public assistance recipients - experience some increase in economic independence following rehabilitation. One-half of the 979 public assistance clients were not on welfare at closure. If these clients can remain free of public assistance, DVR will have achieved a major cost savings. This level of impact would justify reestablishing public assistance recipients as a high program priority. Public assistance clients are not included as a priority in the 1977 State Program and Financial Plan, but JLARC recommends that they should be included due to the demonstrated short term and long term impact on welfare expenditures.

Once a client is accepted for rehabilitation service, he can only leave the system as "rehabilitated" or not rehabilitated. The only requirement for a successful rehabilitation is that the client was employed for 60 days prior to closure. JLARC found that one-third (42) of all 120 cases it reviewed did not receive substantial benefit from DVR services but were closed as rehabilitated. That is, in the judgment of the reviewers, the client could reasonably have returned to employment without DVR intervention. Most of these cases were made eligible on the basis of a mild emotional or mental disorder and received little or no service. None of the case files in question received extensive counseling or were placed in employment through DVR efforts.

Based on JLARC's long-term employment follow-up, DVR has mixed impact in serving the disabled. A substantial number of those clients JLARC could identify as working at closure continued to stay employed. Nonetheless, about a third failed to stay employed. Many of these were behavior disorder cases, drug addicts, and alcoholics--cases which are particularly difficult to rehabilitate because such individuals are often poorly motivated. Furthermore, many of the clients who were classed as having a behavior disorder that failed to stay employed were referred from a correctional facility. A criminal record often limits employment opportunities.

The fact remains that about two-thirds of those with earnings reported at closure remain steadily employed. Some groups, however, are more likely to stay employed than others such as clients with relatively minor disabilities or disabilities easily corrected like surgery for a hernia or the purchase of a hearing aid. Many of these individuals returned to a job held before receiving DVR's assistance. Overall, those who remained employed tended to be somewhat older (over 30 years of age), better educated (at least through high school), female and have a disability that was only temporary in contrast to all of DVR's rehabilitants. Finally, incomes for those that stay employed are low--close to or below the poverty line for many. Those few that did earn higher salaries were generally identified as already working at referral.

Employment levels for clients with severe disabilities is the same or lower than that found for individuals with nonsevere conditions. A key difference, however, is that those with severe physical conditions did particularly well, earning $2,000-$3,000 more than those with a physical condition not considered severe. Based on this, it appears that DVR can, under the new federal guidelines, profitably redirect its efforts toward serving the physically severely disabled on a priority basis.

Except for correctional and welfare units, there did not appear to be any striking differences in the levels of employment and income among special

unit clients. Special units do not appear to have any unique impact. The clients rehabilitated through special units do not show a significant difference in employment over those served through a general field office. The low incomes found among welfare unit clients points out that DVR may not be reducing public assistance to the degree expected. Similarly, the low employment levels and extremely low incomes of correctional unit clients raises a question about how beneficial these units have been.

In short, JLARC found little evidence that DVR counselors were having overall substantial impact. This may be due in part to the fact that counselors must deal with quotas and rehabilitate a certain number of cases each month. Thus, counselors accept individuals that are easily served and likely to take jobs. Quotas also encourage counselors to keep cases open that cannot readily find work. This may contribute to an unwarranted amount of money being spent on unsuccessfully closed cases.

Follow-up of clients after their rehabilitation should be an integral part of DVR's management process. Timely feedback on client performance on a long term basis can be used to guide or adjust the setting of goals and priorities. This information not only can show what areas need improvement, but also can specify the tangible benefits of vocational rehabilitation and identify areas of service delivery that require added evaluation. The JLARC follow-up produces general findings of key client groups and points out what can be expected after their rehabilitation. This type of follow-up used in conjunction with DVR's own system of client contact, should enable the agency to have accurate and reliable management information on program performance.

MANAGEMENT

The development of useful and functioning management practices has not been central to DVR program operations until recently. This chapter reviews the primary components of DVR's management system which includes policy development, priority setting, financial planning, budget administration, personnel control, information utilization and performance evaluation. A critique of these activities is made in terms of the way each element supports the Department's mission of rehabilitating the handicapped.

The priorities used in client selection require reassessment. Only half of DVR's clients fall in a federal or State priority and thus, counselors develop their own priority selection system. In addition, State developed priorities frequently duplicate those set by the federal government. Finally, the existing priority system is disability-based and does not identify other public objectives that DVR could achieve. This chapter recommends certain considerations which might improve the order of selection system including General Assembly review and concurrance in Agency identified goals and objectives.

Controlling counselor expenditures has been a basic problem for DVR. This became most apparent in FY 1976 when it was determined that virtually all client case service funds had been spent or encumbered even though more than half the year remained. Supervisors need to periodically review the rate of counselor spending so that financial shortages will not re-occur. In addition, each counselor's budget should be designed to reflect the agency's priorities.

The Board of Vocational Rehabilitation approved a decentralized service delivery system in 1972. A part of this system called for a larger role for middle-level managers, however, these managers do not yet have the authority necessary to act on certain problems, particularly correcting deficiencies noted in case audits. An improved form of auditing would be to move case audits away from limited reviews of technical compliance to include a judgement about eligibility, appropriateness of service, and client benefit.

A basic problem for the vocational rehabilitation profession has been measuring the quality of each rehabilitation. This chapter reviews the problems faced when counselors are assigned specific quotas based on numbers of clients rehabilitated. Recommendations are made to include appropriate measures of quality.

V. MANAGEMENT OF VOCATIONAL REHABILITATION

Proper management of the vocational rehabilitation effort depends on the efficient and effective application of available resources to achieve program objectives. This section deals with management from a functional perspective by reviewing key aspects of the management process including:

- Policy, Priorities, and Planning
- Budget Administration
- Management Information and Evaluation

The effectiveness of DVR's former management has been brought into question as the result of several audits, reviews, and evaluations by outside agencies. Specific findings dealing with organizational shortcomings were identified as a:

- Lack of top management control;
- Need for better intermediate management control over day-to-day decisions and actions of counselors;
- Need for a comprehensive employee training program;
- Lack of specific measurable objectives in carrying out grants, cooperative agreements, and funding to facilities; and
- Lack of productivity standards for counselors with due regard to client priority.

The Department has acknowledged these problems and, within the past year, has taken initial steps towards addressing several of them. Additionally, a private management consulting firm is now engaged in a review of DVR internal management. However, JLARC's review has identified a number of deficiencies reflecting management weaknesses that deserve immediate attention, can be corrected at little or no additional cost, and can improve program performance. For example, order of selection needs both middle and top management attention. A high proportion of DVR clients are concentrated in disability categories that often produce only minimally handicapping conditions. Thus, DVR supervisors need to actively monitor counselor decisions to ensure that high priority clients are served in accordance with State initiatives.

POLICY, PLANNING, AND PRIORITIES

The need for planning and setting priorities is most often recognized when there is a need to maximize utilization of available resources. Until recently, DVR has not been too concerned with priorities since sufficient fiscal resources were available to satisfy practically all departmental demands. However, current fiscal constraints make it extremely important that DVR be able to calculate the best use of available resources.

Client Service Policy

Although DVR has been establishing priorities for service delivery since at least 1971, there is little evidence that priorities were clearly communicated to Department personnel prior to January, 1976. The federal regulations which implemented the 1973 Rehabilitation Act makes the State responsible for developing an order of selection when all eligible persons who apply cannot be served. It is evident from the estimates of the incidence of disability that every eligible Virginian cannot be served. Furthermore, the type of clients who actually apply for service is primarily a function of the referral network used by each local office (only 10% of all 1975 rehabilitants were "self-referred"). This makes the need for an operationally manageable order of selection which can be adjusted to alter the intake of clients all the more necessary.

The Need for Service Priorities. A satisfactory order of selection policy must, as a minimum:

- meet the needs of the severely disabled and have well defined secondary groups with associated priorities,
- be understandable by and disseminated to all State agency personnel, particularly to counselors and supervisors,
- provide for notification of referral sources and other agencies regarding changes in State agency policies,
- be included in agency procedure manuals,
- be included in any in-service training of agency personnel,
- identify responsibility for the priority system operation at various supervisory levels,
- develop objectives and methods for measuring the functioning of the priority system, and
- provide for follow-up and periodic review of the order of selection policies.[1]

Of most importance is the communication of the order of selection and related performance measures to counselors in a timely and coherent manner. It is of little value to mandate a shift in emphasis to the severely disabled without indicating State policy with regard to the many nonsevere disability groups served. This is particularly critical when budgetary limitations make it evident that all disability groups cannot be served.

The Evolution of Order of Selection Policies

There have been a number of changes in DVR's order of selection policy in the last decade. Generally, these changes have moved from a cost effectiveness

approach to an order of selection based on disability. The principal selection policies are highlighted in chronological order.

The *1966 State Plan of the Virginia Department of Vocational Rehabilitation* identified ten criteria for selecting eligible clients which was generally based on cost or financial factors. These included: potential employability, psychological readiness for service, expectation of success, duration of disability, cost of rehabilitation, availability of personnel and facilities, employment conditions, labor market needs, work expectancy, and the possibility of removal of need of welfare services.

The *1973 Amendment to the 1966 State Plan* specified four criteria which restated but did not substantially change the earlier cost effective orientation. The criteria were: providing service to individuals whose rehabilitation was not shared by another public agency, timely entrance into gainful employment, prevention, reduction or cessation of public support and a reasonable cost benefit ratio.

The *1973 Rehabilitation Act* mandated first priority to the severely disabled. This was a fundamental change that focused selection on disability rather than cost. Additional federal priorities include all Social Security Disability Insurance (SSDI) beneficiaries and all blind or disabled recipients of Supplemental Security Income (SSI). In addition, the Act requires that "special consideration" be given to public safety officers disabled in the line of duty. Beyond these mandated federal priorities, states are free to develop and implement their own priorities for service in accordance with individual program orientation. Approximately one-quarter of all DVR rehabilitations for FY 1975 were rehabilitated under federally mandated priorities. An additional 25% were served as a result of State priorities. Half of the rehabilitants did not have any assigned priority.

The *1975 Program and Financial Plan* (PFP) includes as priorities the severely disabled, the mentally or emotionally disturbed, the mentally retarded, the spinal cord injured, and the deaf and hard of hearing. However, these priorities were not included in the 1975 State Plan issued pursuant to the new Rehabilitation Act, and it is questionable whether they ever became operational at the counselor level.

The *1976 Planning Documents* outline a set of priorities developed both in the FY 1976 PFP and published in Section 8.2 of the State Plan for FY 1976. The PFP lists as priority target groups after all severely disabled, the mentally ill, the mentally retarded, the spinal cord injured, and the deaf and hard of hearing. The key change which occurred between FY 1975 and FY 1976 was the emphasis on just the mentally ill instead of the mentally and emotionally disturbed. This had the effect of shifting a formal priority status away from minimally handicapped behavioral cases.

The *1976 State Plan*, on the other hand, certifies that DVR cannot serve all eligible individuals and, therefore, uses an order of selection. The order meets only minimum federal requirements. The severely disabled are provided first priority. Target groups within the severely disabled category include SSDI and SSI beneficiaries, persons on public support or who are institutionalized, and the severely disabled public safety officer. Secondary priorities for the nonseverely disabled include: (1) eligible persons on public support and (2)

other eligible persons as financial resources permit. It is important to note that the State Plan makes no mention of the more specific PFP priority target groups. This brings into question the ability of the agency to implement its priorities.

The VR-10, *Order of Selection for Priority of Services* form, notifies the client of a general assigned priority status. The VR-10, however, does not include any detail about the priority target group such as disability or other status. If there is any means of implementing the PFP priorities, the VR-10 form would be the logical choice since this is the selection tool used by the counselors. There is considerable redundance among the current priority categories. For example, 60% of the mentally ill, 47% of the deaf, 37% of the mentally retarded, 20% of the public assistance recipients, and all spinal cord injured cases successfully rehabilitated in FY 1975 were severely disabled. Thus, these clients would have been included under the highest priority in any case. An estimated 4,249 of FY 1975 successful closures would belong to at least one of the PFP priority groups. The remaining cases would be in no explicit category except "other eligible persons as financial sources permit".

Based upon the order of selection published in the 1976 planning documents, it is evident there are wide gaps in DVR's system of selecting clients. Those assigned to the lowest of the three priorities represent over 125 different disabilities and place a wide range of needs and demands on DVR's service delivery system. DVR counselors know who has a high priority (the severely disabled) and who is currently in a low priority status (personality disorder cases). However, approximately one-half of all clients fall within the ambiguous category of "other eligibles". The priority assigned this group is solely based on counselor decisions. The counselor establishes an implicit priority system by either limiting referrals to one or two major sources, or limiting the types of clients accepted for service. In either case, there is no guarantee that the resulting informal order of selection reflects desired State policy.

A more positive and coherent order of selection is required. DVR needs to extend its coverage of disabilities that are included in a priority category beyond the 50% now covered. While the type of disability will remain a primary factor in any future determination of priority, other factors such as the emphasis until FY 1977 on public assistance recipients can and should be used to ensure that the order of selection reflects existing or yet to be developed State goals and objectives.

Priority Development

Priority setting for vocational rehabilitation can be a complex process and, as such, should be guided by the best information available. Prior to 1973, DVR's priorities were based on cost effectiveness and equity of service measures; however, it is questionable whether these priorities were ever implemented. With the 1973 Act's mandate, the first priority was given to the severely disabled. DVR had developed other priorities for the mentally ill, mentally retarded, spinal cord injured, and deaf and hard of hearing. These priorities were not implemented either, and are deficient in that they are based simply on disability and do not reflect public goals to be achieved. Other factors are available that can be applied to nonseverely disabled cases in accordance with State identified goals and objectives. For example, the following factors could be considered:

- the cost of rehabilitation in terms of reasonableness;
- the extent to which similar benefits are or are not available to finance rehabilitation;
- the opportunity to contribute to a reduction or elimination of public assistance;
- the demonstrated program impact after rehabilitation on certain client groups in employment and income; and
- the extent to which specific public services are available that can be used in combination with DVR services to deal with long term or multiple disabilities.

If, for example, a DVR goal is to reduce dependance of the handicapped on public assistance, then all disabled welfare clients should receive priority service. On the other hand, if the goal is to keep rehabilitation costs reasonable in relation to the nature of the disability, then DVR should only permit high cost training services for the most severely disabled.

DVR should develop a priority system that considers a variety of factors including, but not limited to, type of disability. This system should be made operational at the counselor level and be an integral part of routine audit and data collection. JLARC recommends that DVR submit the proposed priority selection process to the General Assembly for review and approval to ensure full legislative agreement on service objectives.

Planning

Planning information is helpful in identifying approximate levels of the number of handicapped individuals who are eligible. However, there is a need to also develop more specific data which shows the rate of eligibility for "different segments of the handicapped population".

Program and Financial Plan. Since 1970, DVR has published an annual Program and Financial Plan (PFP) which shows short and mid-range projections of the number of clients to be served and rehabilitated. In addition, the PFP specifies the number of clients they will serve in priority service target groups. Table 20 shows the number of clients to be served in each fiscal year. The shifts in client groups are clear. Four groups--the mentally retarded, mentally ill, spinal cord injured, and deaf and hard of hearing--are included each year and continue to increase. These four disabilities are not federal priorities except to the extent they also represent severely disabled clients.

On the basis of actual performance in rehabilitations measured against planned rehabilitations, the agency demonstrates a creditable planning record. Table 21 shows the projected and actual number of clients rehabilitated between FY 1971 and 1975. The problem of redundancy between priorities from 1973 to 1975 is illustrated in Table 22. For example, almost all of the spinal cord injured and about half of the deaf clients rehabilitated are severely disabled. The other

Table 20

PRIORITY SERVICE TARGET GROUPS
Fiscal Years 1971-1977

	To Be Served						
	FY 71	FY 72	FY 73	FY 74	FY 75	FY 76	FY 77
Disabled Public Assistance Recipients[a]	--	1,500	3,600	3,800	3,800[d]	3,520[d]	--
Alcoholics[a]	--	--	400	400	--	--	--
Drug Addicts[a]	--	--	300	250	--	--	--
Severely Disabled[a]	--	--	--	--	14,640	15,340	15,315
Disabled Public Offenders	--	650	1,500	1,500	--	--	--
Mentally Retarded	2,500	2,000	5,000	6,000	12,000	12,100	8,314
Disabled Model City Residents	--	400	--	--	--	--	--
Mentally Ill	1,200	1,500[c]	3,600[c]	4,800[c]	12,320[c]	12,105	13,127
Behavioral Disorders	1,500[b]	2,000	--	--	--	--	--
Cord Injured	125	125	400	500	400	500	875
Deaf and Hard of Hearing	400	400	1,200	1,500	1,000	1,200	2,625
Cardiac	--	--	--	--	--	--	2,625
Total	5,725	8,575	16,000	18,750	44,160	44,765	42,881

[a]Federally mandated priority service target groups for years data is present.
[b]Includes public offenders, drug abusers, alcoholics.
[c]Includes emotionally disturbed.
[d]Not a federal priority in these years, but continued by DVR.

Source: RSA, Program and Financial Plans, 1971-1977.

Table 21

INDIVIDUALS REHABILITATED, PLANNED, AND ACTUAL
FY 1971-75

	1971	1972	1973	1974	1975
Planned Rehabilitants (Section 110)	11,500	12,000	14,200	14,000	11,600
Actual	10,537	12,221	13,246	13,647	9,139

Source: RSA, Program and Financial Plans, FY 1971-75 and Annual DVR Statistical Summary, FY 1971-75.

major problem in implementing priorities is the very large gap between planned goals and actual performance in the case of spinal cord injured and deaf clients. The difficulty in implementing these goals also shows up in the two cases where disabilities were dropped as a priority. Rehabilitation of alcoholics and drug addicts continued at the same or even greater rate after termination of these priorities (some of this volume is due to the effect of clients already being

Table 22

PLANNED AND REHABILITATED PRIORITY SERVICE TARGET GROUPS
FY 1973-75

	1973		1974		1975	
	Planned	Served	Planned	Served	Planned	Served
Severely Disabled[a]	--	--	--	--	2,740	2,238
Alcoholics	200	214	200	244	--	170
Drug Addicts	150	94	125	227	--	208
Mentally Retarded	2,500	2,370	2,700	2,027	2,685	1,204
Cord Injured	200	18	250	53	200	60
Deaf and Hard of Hearing	600	391	750	394	500	331

[a]Federally mandated priority.

Source: RSA, Program and Financial Plans, FY 1973-75 and Annual DVR Statistical Summary, FY 1973-75.

accepted). Other selection difficulties are seen in serving the mentally retarded--a priority for each of these three years. While the planning level remained steady, the number of clients rehabilitated showed a major decline from 2,370 to 1,204. This may reflect expanded service to the severely disabled since moderate and severe retardation is considered a severe disability. If this was the intention of DVR, the planning goal for the mentally retarded should be reduced to reflect service to the nonsevere mildly retarded while the number of severely disabled should increase.

Operational Planning. The failure of DVR's planning process occurs not at the PFP level but at the operational level where planning goals (and the priorities they reflect) are transmitted to counselors. The major shortcoming is that, while planning is based on disability, there is no documentation as to how these goals are to be implemented. Implementation needs to take place through emphasis on referral sources. DVR has not stated which sources are to be given priority, nor is there any analysis to permit this establishment of priorities. Furthermore, there is no active reporting system within DVR which allows management to measure performance against goals for each disability, as well as holding counselors accountable for serving priority cases.

BUDGET ADMINISTRATION

Careful administration of appropriated funds is necessary to ensure that expenditures are in keeping with organizational priorities and budget time frames. This means that each organizational unit must periodically assess its rate of spending. A central budget office must also prepare and analyze information on expenditure performance to monitor the agency's overall progress compared with its budget.

The uninterrupted financial growth of DVR over the last ten years came to an abrupt halt in November, 1975, when it was discovered that virtually all

case service monies available for FY 1976 ($13,551,647) had been either encumbered or spent. Officials indicated that several factors contributed to this problem:

1. On July 1, 1975, the share of case service monies that DVR was to provide the Commission for the Visually Handicapped was increased from 10 to 12½%.

2. A 4.8% pay increase for all State employees was effective July 1, 1975.

3. DVR assumed that $720 million would be appropriated for vocational rehabilitation nationally by Congress (the President recommended $680 million last December, but Congress eventually overrode a veto and restored funding to the $720 million level).

4. The expiration in October, 1975, of Public Assistance-Vocational Rehabilitation Grants. These grants supported clients with 90% federal funds and had to be maintained with the basic support funds which are 80% federally funded.

5. A decline in the portion of federal case service monies available to Virginia since the State's per-capita income has been increasing.

6. Action on the part of the Division of the Budget in denying DVR use of $2.6 million in surplus funds which the agency had accumulated from special fund revenues. DVR was allowed to retain $1 million of this surplus, but the balance reverted to the State Treasury.

This last reason is the only significant factor affecting DVR's budget encumbrance problem. The first five factors were anticipated and should have been planned for. In the case of cost assumptions based on Congressional appropriations, it would appear to have been more realistic and responsible to plan based on the lower figure of $680 million. The reliance on a special fund surplus highlights the need for DVR to plan based on clearly identified and legitimate sources of revenue.

Disposition of Surplus Funds

The Division of the Budget took action in October, 1975, to deny DVR use of special fund revenues which had accumulated for at least three biennia. The fund balances began to grow as DVR provided services to clients at mental hospitals, correctional facilities, and school districts. These units certified to DVR the cost of personnel and facilities that they would provide in order to earn federal funds. DVR combined these certifications with general fund appropriations in order to earn federal matching funds. The total amount of certifications and general fund appropriations would be used to meet the prescribed ratio of 20% State and local funds needed to earn the 80% provided through federal support.

The balances developed when amounts that were certified by one of the special units exceeded the amount planned to match federal funds. In addition, if one of the special units did not spend all the money earned, the balance remained in DVR's special fund account. For example, a mental hospital would claim that they provided $20,000 in certifications of personnel and material. This would generate $80,000 in federal revenues. However, if the unit did not spend the entire amount, the balance was retained by DVR. This matter came to the attention of HEW auditors who specified that, in the future, agencies should appropriate the amount needed to earn the federal matching funds rather than certify the resources used. This is currently the practice in Virginia.

At the end of the 1972-74 biennium, the balance of these surplus funds stood at $3,028,323. One year later, on June 30, 1975, the balance had grown to $3,683,784. At this point, the Division of the Budget permitted DVR to retain $1 million for case services in FY 1976, but the balance of $2.6 million was reverted to the State Treasury.

Impact of Agency Controls

When DVR discovered they were overextended on spending, a moratorium was placed on new case service expenditures. This action essentially denied normal program services to almost all clients except those directly funded by the Department, such as services from the Woodrow Wilson Center. Many counselors remarked to JLARC interviewers that certain aspects of this moratorium were desirable since it forced them to seek out third party sources of financing client's programs (something they had been required to do all along, but had not done routinely).

JLARC findings confirm that counselors have not properly utilized third party funding sources. As was shown in the similar benefits section of Chapter 3, four service options--restoration, college training, business school, and maintenance--are almost entirely financed by DVR. This fact would call into question the department's effort at using alternative funding sources. Since almost 90% of all college training cases were fully funded by DVR, this raises questions about use of the many tuition assistance and scholarship programs which are available.

An aspect of the moratorium which counselors found beneficial was the need to budget and prioritize spending. With the large amounts of case service monies available in previous years, this need was not so apparent. While there were some positive management aspects to the moratorium, the primary effect was negative since program operations in terms of client service were virtually halted. A stronger commitment to proper financial planning, budgeting, and expenditure control is essential if DVR is to avoid another financial crisis of this nature in the future.

Financial Controls

The size and complexity of DVR's field operation requires that effective and responsive controls be established so that staff and fiscal resources can be used to their optimum advantage. However, the financial history of the Department has not encouraged the development of this type of control system

since, until recently, there have been sufficient funds to meet not only anticipated expenditures but also cover instances where counselors did overspend their budget. The issue of management controls was brought out in two ways; (1) the Special Grand Jury Report of the Circuit Court of Richmond found in December, 1974, that funds intended for clients were used for purposes which were not legal or authorized; and (2) the fact that DVR had either spent or encumbered most of their FY 1976 budget for client case services with more than half of that fiscal year remaining. An additional management control weakness encountered is that DVR has not fully implemented a decentralized organizational structure whereby regional and field office supervisors are to have greater authority in decision making and enforcement.

A Regional System of administration was initiated in January, 1972, when DVR's Board adopted a decentralized organization consisting of regional directors in four locations--Roanoke, Annandale, Richmond, and Norfolk--responsible for carrying out the department's service activities. The four regions of the State and the distributions of staff and units are shown in Table 23.

The regional delivery system has been only partially implemented. The State office still retains decision-making authority which should be delegated to regional directors and supervisors if the system is to be effective. For example, an important function conducted at the supervisor level is the auditing of counselor caseloads. The audit is to include "the overall casework flow, counselor strengths and weaknesses, a plan for strengthening counselor weaknesses, and a timetable for plan completion...". After an audit, supervisors report the results to the Regional Director within ten days. Regional Directors:

- acknowledge receipt;
- analyze the findings;
- recommend further action; and
- transmit a copy to the State central headquarters office program director.

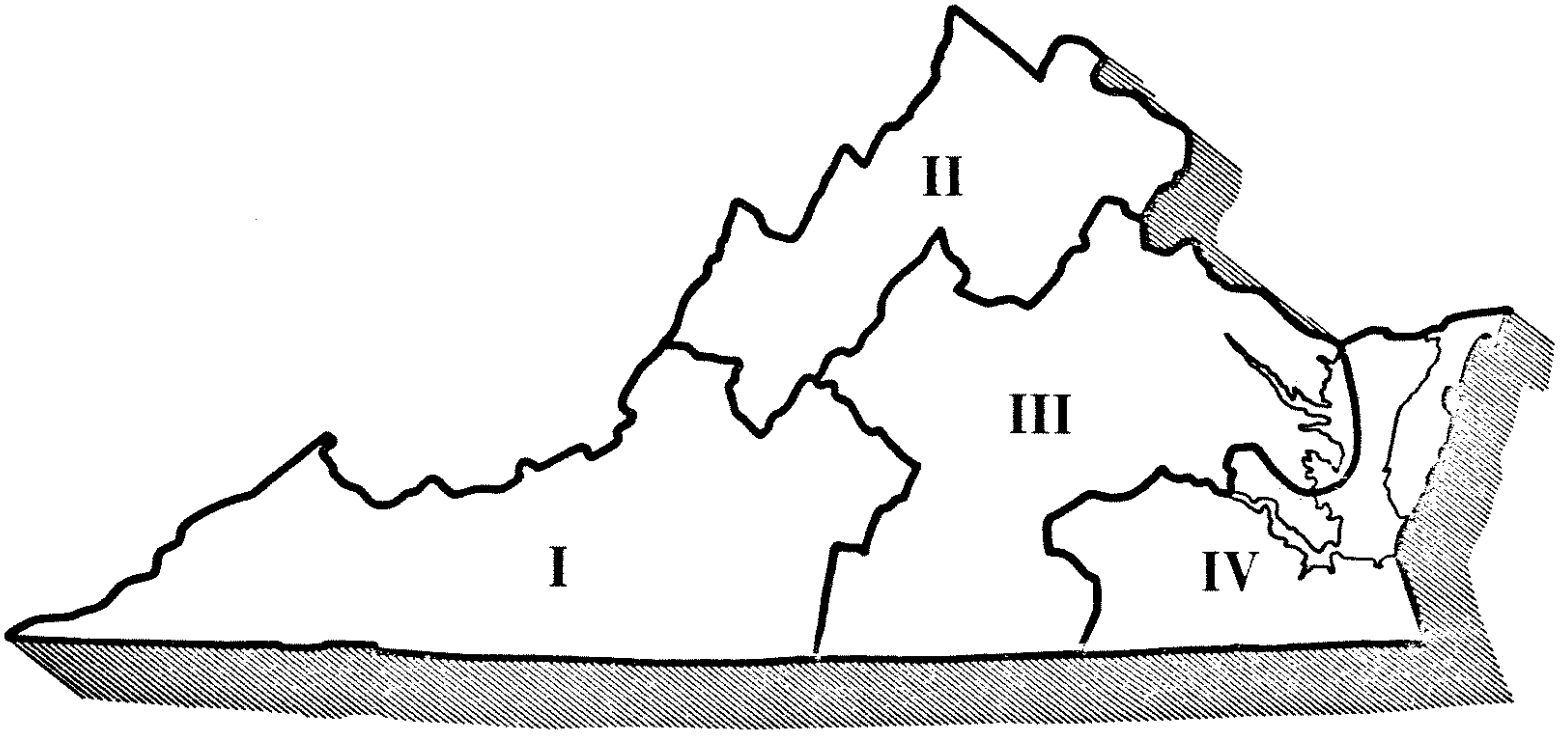
Regional Directors lack the authority to take direct action in the case of audit findings. This role for the regional director is not limited to auditing. In fact, the guidelines for regional directors state, "In general, the regional director acts in all staffing and personnel matters by noting his observations and making recommendations to the agency personnel supervisor with a copy to the program director". A more explicit and formalized role is necessary for regional directors to effectively implement the system of decentralization and regionalization. It is recommended that, commensurate with the decentralized organization, a greater degree of decision-making authority should be delegated to regional directors.

Functional Budgeting

A major problem facing DVR is the need to develop a functional budgeting system based on agency priorities and objectives. During the fourth quarter of each fiscal year, counselors advise supervisors of the amount they need for the next fiscal year. These projections are generally based on expenditures and clients served in the previous year. Supervisors and regional directors combine counselor requests and transmit the total to the State office. It was found, however, that these requests were not consistent and often overstated requirements

Table 23

REGIONAL DISTRIBUTION OF DVR FIELD UNITS AND PERSONNEL - 1975



Region 1 - Southwest

Personnel	
Regional Director	1
Program Supervisors	4
Unit Supervisors	4
Counselors	55
Units	
Area and Field Offices	11
Welfare Projects	3
Hospital Units	2
School Units	1

Region 2 - Northern Virginia

Personnel	
Regional Director	1
Program Supervisors	3
Unit Supervisors	5
Counselors	50
Units	
Area and Field Offices	8
Welfare Projects	1
Hospital Units	2
School Units	3
Evaluation Centers	1
Corrections Units	1

Region 3 - Central

Personnel	
Regional Director	1
Program Supervisors	3
Unit Supervisors	3
Counselors	59
Units	
Area and Field Offices	4
Welfare Projects	3
Hospital Units	2
School Units	4
Evaluation Centers	1
Corrections Units	1

Region 4 - Tidewater

Personnel	
Regional Director	1
Program Supervisors	7
Unit Supervisors	5
Counselors	68
Units	
Area and Field Offices	9
Welfare Projects	3
Hospital Units	2
School Units	1
Evaluation Centers	1
Corrections Units	3

Source: DVR Directory, April, 1975.

since the only official guidance published is that "the supervisor will request necessary funds for efficient program operation". Criteria are not made explicit as to what constitutes efficient program operation. In addition, there is no direct recognition given to the fact that the cost of operating the various types of caseloads vary and that this effects the type of budget to be developed. Finally, no attempt is made to incorporate agency objectives and priorities in this process.

A common theme that ran through most of the Regional Director and supervisor interviews was that budgeting skills and techniques were not commonly required since the agency consistently had sufficient funds to cover client case service costs. The need to budget and to plan use of financial resources is critical, particularly in light of the severely disabled mandate. This latter aspect has been stressed by RSA:

> There is nothing simple or obvious about controlling a State agency's resources of personnel and money. Existing resources often have commitments for their use that are not compatible with priority services for the severely handicapped. Yet, no matter how sincere a State agency is in serving the severely handicapped, unless a built-in plan of allocating resources is implemented, positive program changes will not occur.[2]

It is recommended that an operational budgeting system be implemented by DVR. This system needs to incorporate financial recognition of agency priorities and the financial and program characteristics of each caseload. Spending limits for each region should be set by the Financial Director and Operational Division personnel should establish program budgets that address agency objectives.

Review of Counselor's Expenditures. The current amount of supervision over purchases made by counselors for clients varies considerably. The most frequently cited control tools were the monthly reports of all active clients (master list) and the expenditures made for the clients (case cost report). Although the data in these reports are a month old when received, nine of the twenty-eight supervisors interviewed cited either or both sources as the way in which they reviewed and controlled counselor expenditures. The next most cited controls were self-designed instruments (six supervisors) or the Individual Written Rehabilitation Program (VR-5) (five supervisors). A factor that bears out the diversity and lack of uniformity in using expenditure controls is that three supervisors indicated they had no controls while three others indicated they routinely required counselors to obtain prior approval for expenditures either on a random basis or if there were undocumented case service purchases. This lack of standardization in supervisory controls is a critical failure given the environment the agency currently faces of limited or curtailed case service expenditures.

JLARC found several examples of monitoring systems being used within the Department which could serve as a model for the entire agency. These systems provide counselors sufficient information to measure progress against the annual budget. Also, monthly progress reports should specify where the counselor stands in relation to his or her yearly allotment for case service and travel monies. These types of monitoring devices are desireable in terms of controlling counselor fiscal activities.

Major problems mentioned by supervisors in using the current system are:

1. Case cost reports arrive too late to use meaningfully;

2. The expenditure reports have limited usefulness for Regional Directors since they fail to specify activity on an area and field office basis;

3. Announcements of the allocation to be received by each unit arrives after the start of the fiscal year when the program plans become effective; and

4. Allocations received by each region have general rehabilitation money and Trust Fund money together. These have to be broken down into their respective amounts and the State office does not do this until later.

The current informal controls that exist over case service expenditures may have led indirectly to DVR's encumbrance problem. JLARC interviews revealed that in the past counselors could overspend the amount budgeted. This was possible since they could use funds from other counselors who had not expended their entire budget or through DVR requesting additional case service funds from RSA. Unexpended balances from other states could be redistributed to states that still had a need for case service monies. The way in which counselors spend case service monies is controlled for individual purchases by a voucher approval process. However, the annual rate of spending is not controlled. JLARC recommends that DVR consider formal controls that supervisors and Regional Directors can use to establish each counselor's total budget for the year; a procedure to review on at least a quarterly basis counselor spending in relation to the approved budget; and a method to adjust deviations in counselor spending patterns within field offices and within regions.

The Internal Caseload Monitoring and Review process of DVR is adequately developed in guidelines which direct the actions of regional directors and program and unit supervisors. Supervisors have the responsibility to monitor and evaluate counselors in their assigned duties and responsibilities. Prior to December, 1975, supervisors were to audit ten cases of every counselor each quarter. This requirement has been downgraded to require an audit of three cases each quarter. Cases are selected randomly and the audit includes contacting the employer, client, and vendor. These activities are desireable; however, more than three cases should be audited each quarter if DVR is to have acceptable levels of confidence in the results.

Audit requirements are in the process of some change. A system of auditing is now being reviewed in which an audit task force, under the supervision of personnel from the Program Evaluation Unit, audit large samples of open and closed cases. This should occur at least annually to ensure better case coverage than ever before. To the extent that this new system will increase case coverage and contribute to improved audit techniques used by supervisors, it should be helpful. During interviews, supervisors continually stressed the unreasonable demands that caseload auditing required of them (to the extent that one supervisor stated that if he audited cases as he was supposed to, it would require 35 hours each week).

In their present form, case audits are compliance reviews and do not address appropriateness of service, effective planning, or program eligibility. The way that standards are currently developed ensures only that minimal standards are observed in terms of documenting paper work. Moreover, the auditor is not required to evaluate frankly whether the client benefited from contact with DVR. More needs to be done to monitor eligibility, effectiveness of planning, and the appropriateness of services. JLARC recommends that DVR move both supervisory and centralized case auditing in the direction of more attention to assessments of client benefit and case quality rather than the traditional compliance audit, which is limited to verification of file information. The latter type of review should also be conducted for each region but on a centralized basis using statistical sampling techniques. This would assure representation, reduce the demand on valuable supervisory time, and increase audit coverage of the case files.

MANAGEMENT INFORMATION

Accurate, relevant, and timely information can greatly enhance the quality of decisions that are made by agency and program managers. As with all information systems, the final quality of the product is only as good as the quality of the input. Management information has taken on increased importance in recent years as heavier reliance has been placed on agency generated information to provide: (1) public accountability for funds appropriated and (2) basic data for evaluating program performance.

System Limitations

DVR has a sophisticated data processing system which is of value to the counselors in maintaining their caseloads. However, some improvements could be made. First, the existing system is not fully used to produce the kind of management information necessary for top management decisions. Second, JLARC found a number of errors in the data which were reported to RSA as part of the required federal reporting system.

Two improvements in the monthly reports provided to counselors could be beneficial.

Combining the Master List and Case Cost Report. These two reports are the framework for counselor record keeping. Generally, JLARC found that counselors were satisfied with these reports. However, the Master List has data relating to client status and demographics, while the Case Cost Report includes data on expenditures made for each client. Since all of these data are necessary for caseload management, it would be beneficial to have them combined in one report.

Timeliness of Reports. Counselors indicated that there is a considerable time lag before expenditure data are received from agency headquarters. Obviously, the collection of statewide data and the preparation and circulation of reports is time consuming. However, DVR should review its procedures to ensure that reports are disseminated in the most timely manner possible.

JLARC also found that the way in which data reports are used presents a problem for program managers. In one instance, a Regional Director stated that case cost information is largely worthless because it does not include other information on disability and severity. DVR has the capacity to provide management information such as the *Summary of Case Service Reports* which is prepared at the end of the fiscal year. However, it is necessary to have this kind of information on a routine basis during the year so that program managers can note trends or patterns and use it for decision making. Presently, DVR is overly concerned with data processing and historical records and not sufficiently concerned with information for current decision making. The development of the MAPS management information system, discussed in the next section, may help to alleviate this problem.

JLARC found the information included in the computer tapes submitted to RSA (Federal Quarterly Closure Report, RSA-300) were not always accurate. Information reported should be validated to ensure that the nationwide statistics prepared by RSA accurately reflect Virginia's activity. Of 120 client's case files reviewed, JLARC found 29 instances where the number of months recorded on the VR-4E (months in status 18 and months in status 20-22) and the data reported to RSA differed. In some cases, there were sizeable discrepancies--11 months (2 cases) and 8 months (1 case).

DVR has indicated it will reconcile these discrepancies by relying solely on the data reported automatically in the Master List and thus bypassing the data reported by counselors on the VR-4E. This may compound the problem since the counselor should be the most authoritative source of information on the length of time in status. The problem does confirm the need expressed in RSA's *Statistical Reporting Manual* "that each State agency make periodic sample checks of case files to assure itself of the quality of the data as reported".

Another problem occurred in identifying severely disabled cases for the Quarterly Closure Report. Although DVR reported 2,239 severely disabled rehabilitations in their written report, a review of the computer tapes used as the source for the report revealed that only 1,747 cases were coded as severe. Analysis of this tape showed 346 cases with a primary disability which would have automatically qualified the client as severely disabled but were not coded as such. This understates severely disabled rehabilitations by 22% and suggests confusion at the counselor level regarding how to identify the severely disabled. Of the 120 case files reviewed, JLARC found six with different primary disabilities reported on the VR-4A form (Certificate of Eligibility) than were reported on the Quarterly Closure Report. This is a potentially serious problem since there is no explanation in the case file as to why the differences existed. If the nature of the disability was, in fact, changed before closure, the Certificate of Eligibility should have been amended.

The Management Planning System (MAPS)

A recent change to DVR's management process should affect the way the agency's information is developed and used. In January, 1976, DVR received Board approval to begin implementing a Management and Planning System (MAPS) to "provide basic guidance for establishing a more effective and efficient system of management and planning".[3] MAPS is intended to have impact on all divisions, by providing them with an improved management and planning process. The most

specific output of MAPS will be the two plans that are now required by RSA--the annual State Plan and the PFP.

One of the processes of the MAPS system is to integrate functions by the "...major components of the agency in a way that yields an interlocking and mutually supportive total effort toward achieving common goals". This is important since it was observed that greater interaction and cooperation are needed between administrative, operational, and planning units of this agency. For example, program (VR-99) and financial data (VR-97) are now reported separately to supervisors and counselors. Similarly, budgets submitted to the State office specify each counselors' anticipated financial need, but the format is not standardized. Field visits revealed a number of budget development procedures, but principal reliance is placed on the prior year expenditures. To the extent that the MAPS system will integrate administrative, operational, and planning needs, then it should resolve some of these problems. However, the MAPS approach does place major responsibility on the Operations Division to integrate information.

> In essence, the Division of Operations manages the agency's resources because it is responsible, along with Woodrow Wilson Rehabilitation Center [WWRC], for the direct delivery of VR services to clients. Because ultimately the work of other agency components is meant to effect the delivery of services, the Division of Operations must assimilate and integrate a vast amount of information and data generated by these other components and add information it has collected to form a total picture.

For this integration to occur, strong liaison between Operations and other DVR divisions is essential. The Operations Division must specify its data requirements to support divisions in a very precise way so that they will be able to provide meaningful information.

Agency Expenditures

Of the six major categories under which DVR expends funds, the largest category is service to individuals which represents all services purchased by field counselors. Services can be purchased through public vendors such as the Woodrow Wilson Rehabilitation Center or financed through private vendors. These costs steadily increased from $3.4 million in FY 1967 to $12.4 million in FY 1973. During this period, they represented over half of DVR total expenditures. Since FY 1973, however, services to individuals dropped sharply to $7.8 million in 1974 and $8.7 million in 1975. At these levels, they represent approximately one-third of total expenditures. This decrease in services to individuals was offset by corresponding increases in the percentage of funds used by specialized facilities and programs. These grants do provide services to individuals but not to the extent that the general field program does.

Analysis of DVR's expenditures for FY 1975 shows that 45% of all expenditures were for client services, with the field program and special projects accounting for the majority. Fiscal year 1975 expenditures by purpose are presented in Table 24. The second largest area of expenditure was personal services, constituting 31% of all expenditures.

Table 24

DEPARTMENT OF VOCATIONAL REHABILITATION
Analysis of Expenditures by Purpose (FY 1975)

Purpose	Personal Service	Contractual Services	Supplies & Materials	Grants & Shared Revenue	Equipment: Replacement	Equipment: Additional	Current Charges & Obligations	Pensions & Retirement Allowances	Case Services	Total
Administration	$ 650,892	$ 209,710	$ 25,743	$ --	$ 891	$ 5,660	$ 96,825	$ 59,816	$ --	$ 1,049,537[1]
Percent	62%	20%	2%		1%	1%	9%	5%		
Disability Determination	1,728,832	1,387,705	48,514	3,822	--	50,395	349,783	175,472	--	3,744,523
Percent	46%	37%	1%	1%		1%	9%	5%		
Drug Rehabilitation Program	106,991	3,393	--	--	--	--	--	9,419	281,737	401,540
Percent	27%	1%						2%	70%	
General Rehabilitation Services (Field Program)	2,571,644	936,861	97,756	--	28,694	158,383	313,356	241,527	8,572,830	12,921,051
Percent	20%	7%	1%		1%	1%	2%	2%	66%	
Correctional Institutions	387,635	28,857	16,071	--	2,143	3,839	4,611	38,859	91,846	573,861
Percent	67%	5%	3%		1%	1%	1%	6%	16%	
Public and Private Agencies										
School Units	533,841	147,433	13,792	--	1,454	13,262	6,141	51,677	485,678	1,253,277
Percent	42%	11%	1%		1%	1%	1%	4%	39%	
Sheltered Workshops	--	141,734	3,931	--	--	167,435	257	--	--	313,357
Percent		45%	1%			53%	1%			
Mental Institutions	879,557	52,071	22,246	--	8,473	33,691	6,086	84,291	394,424	1,480,839
Percent	59%	3%	1%		1%	2%	1%	6%	27%	
Special Projects	1,675,226	1,105,512	11,031	12,809	4,926	26,719	91,013	144,959	2,398,151	5,470,347
Percent	30%	20%	1%	1%	1%	1%	1%	2%	43%	
TOTAL	$8,534,618	$4,013,276	$238,046	$16,631	$47,619	$459,384	$868,072	$806,020	$12,244,666	$27,208,332
Percent	31%	14%	1%	1%	1%	2%	3%	2%	45%	

[1]This appropriation was credited with $154,097 due to recoveries of equipment and tools.

Source: Department of Vocational Rehabilitation, "Expenditure Report by Division" VR-97, June 1975.

Personnel

The entire work force of DVR has shown major growth over the last decade. The number of DVR personnel (including those at Woodrow Wilson) has nearly tripled from 559 in FY 1966 to 1,499 in FY 1975. Table 25 specifies the number of positions filled and vacant by category for three years--1966, 1970, and 1975. The largest group of professional employees are the rehabilitation counselors. The clerical category accounts for the largest increase from 125 positions in 1966 to 450 in 1975.

Secretarial Support. The clerical support provided each DVR counselor is critical since JLARC found that counselors assign major responsibilities to secretaries in addition to handling the high volume of paper work involved in casework. In assessing the clerical support, JLARC staff asked counselors whether their time could be better utilized with more secretarial support. The majority indicated that added secretarial support will not enable them to better use their time.

Counselor Aides. Another method of reducing counselor workload is through the use of counselor aides. In FY 1975, DVR had 33 Rehabilitation Counselor Aides who assist counselors in "performing routine duties in connection with determining the eligibility of prospective vocational rehabilitation clients". Of the counselors interviewed by JLARC, 60% indicated that their time could be better utilized with a counselor aide, since the aides can perform the more routine aspects of counseling.

Table 25

PERSONNEL POSITIONS
DEPARTMENT OF VOCATIONAL REHABILITATION
(1966, 1970, 1975)

		Filled	Vacant	Total
1966	Total	284	56	340
	Professional	171	38	209
	Clerical	109	16	125
	Other	4	2	6
1970	Total	556	113	669
	Professional	330	75	405
	Clerical	208	27	235
	Other	18	11	29
1975	Total	918.5	184.5	1103.0[1]
	Professional	502.5	96	598.5
	Clerical	370.5	80	450.5
	Other	45.5	8.5	54.0

[1]Includes approximately 300 personnel of the Disability Determination Division.

Source: "Positions as of December", for each year, Division of Personnel.

The rapid growth and expansion of DVR has:

> ...affected both its system of in-service training and staff development. During this period, employees were hired at entry levels with less specialized education than desired. This was due partly to the inability of universities and colleges to turn out the numbers needed as well as to the state of rehabilitation counseling as a professional.[4]

JLARC encountered several specific factors which affect staff development. One area is turnover among counselors. This was used to explain lower levels of successful rehabilitants in areas where there is a more transient professional population like Northern Virginia. A positive step taken by DVR is the entry level training of counselors since it was found that counselors benefited from a one-week introductory training class provided all new counselors. In addition, JLARC found that one-third of the counselors interviewed held a masters degree (usually in rehabilitation counseling) while another third had some graduate work.

A factor affecting State office management is that essentially all personnel in line or staff positions are former counselors. "Experience and some capacity for becoming good managers became the criteria for mobility. Counselors who were not interested in management, as well as noncounselors, found their mobility very limited."[5] A structural problem forces counselors into management since the maximum amount of time in which a counselor will continue to receive merit increases is seven years. This is a considerable disincentive for the many counselors that wish to remain in the counseling field. JLARC found that most counselors would prefer the establishment of a counseling career ladder that would provide financial incentives beyond seven years. This would also impact staffing of DVR management positions since the agency could recruit from the various management disciplines instead of relying on the counselor work force to staff their top management positions.

Counselor Productivity

A detailed analysis of DVR counselor's FY 1975 workload and case service expenditure patterns was conducted as part of the JLARC review. This analysis included 232 counselors and focused on the geographic differences in clients served, funds expended, and variations in activity between general counselors and those assigned to six special programs. Certain caseloads had no counselor assigned for a substantial part of the fiscal year, so the comparative statistics are based on a total of 223 counselors.[6]

The JLARC analysis found substantial variation exists among the productivity of both general and special counselors. For example, about one-quarter of all DVR counselors (almost all having general caseloads) produce almost half of all rehabilitations while one-third of all counselors (most with specialized caseloads) produced 12% of all rehabilitations. A principal factor accounting for the difference is that the number of clients rehabilitated who received only surgery or hospitalization. These cases are generally easier to process, take up less of the counselor's time, and are likely to be successfully closed. Rural areas tend to have more of these cases and, therefore, appear to be more productive.

Table 26

REGIONAL DISTRIBUTION OF WORKLOAD MEASURES OF 1975 ACTIVE CASELOADS[1]

Measure	Region				State Average
	Southwest	Northern Virginia	Tidewater	Central	
Cases per counselor, June, 1975	155.1	154.7	127.0	134.4	141.5
Eligible closures	73.1	57.9	65.6	61.2	64.6
Rehabilitations	49.8	40.4	39.4	35.0	40.9
Percent of all closures which were eligible closures	40.6%	42.4%	44.6%	47.9%	43.7%
Rehabilitation rate	67.2%	67.9%	58.0%	55.5%	61.7%
Expenditures authorized	$64,939	$62,391	$54,287	$51,034	$57,717
Expenditure for:					
Diagnostics	17%	18%	12%	21%	17%
Restoration	34%	28%	21%	20%	25%
Training	27%	34%	35%	35%	33%
Maintenance	16%	10%	25%	17%	18%
Transportation	4%	7%	5%	4%	5%
Other	2%	4%	2%	3%	3%

[1]Comparative measures based on 223 caseloads: 53 in the Southwest Region, 48 in Northern Virginia, 58 in the Central Region, and 64 in the Tidewater Region.

Source: JLARC workload analysis for FY 1975.

The measures shown in Table 26 reflect averages in each of the four regions and the State and show the differences that exist.

Southwestern Virginia was considerably more active on a per counselor basis than were counselors in the other three regions. This region had a substantially greater number of cases, eligible closures, and rehabilitations per counselor than did the rest of the State. Per counselor, expenditures for the Southwest region ($64,939) were also higher than the rest of the State. The primary explanation of this difference is the proportionately greater expenditure for restoration (surgery) service. As discussed in Chapter 3, clients in need of restoration service are more likely to be employed at referral or to have a job skill or work experience. Southwestern Virginia counselors serve more of these types of cases and, therefore, can close more eligible cases and expect more of these clients to return to work or find other employment.

Analysis of the geographic distribution of workload indicated that DVR offices, which serve more rural areas, tend to have higher numbers of rehabilitations per counselor. For example, DVR general field offices generating the most rehabilitations per counselor were: South Boston, Radford, Marion, St. Paul, Danville, Woodbridge, Richlands, Roanoke, Salem, Winchester, and Hampton. In contrast, the offices with the lowest number of rehabilitations per counselor were Hopewell, Culpeper, Waynesboro, Richmond, Lynchburg, Petersburg, Norfolk, and Portsmouth.[7]

Workload Variation Between DVR General and Special Programs. In addition to regional variation, there were distinct differences in the distribution of workload between general and speciality counselors. Of the 232 active caseloads, 121 were classified by JLARC as general. (Many of these "general" counselors, however, tend to specialize in particular types of clients because of their assigned referral sources.) There were 111 specialized caseloads--welfare, corrections, schools, mental health, drug, and deaf. Some of these caseloads were specialized in name only, since some of these counselors (particularly welfare) do serve a general population.

Although the counselors assigned to the specialized caseloads represent about half of all DVR caseloads, the workload measures indicate these counselors serve and rehabilitate substantially fewer persons than the general field office counselors. General counselors averaged 50 rehabilitations per counselor compared to 31 for special counselors. General counselors also spent almost 3 times as much as special unit counselors ($78,200 compared to $28,000). In total, general unit counselors, although representing only 52% of all counselors, spent 76.8% of all case service money.

Table 27 shows the six categories of DVR special units and the differences of workload and expenditure activity associated with each.

Certain of these specialized caseloads produce fewer rehabilitations as a result of the type of client served or the nature of the DVR unit. For example, caseloads assigned to mental hospitals and correctional units generate fewer reported rehabilitations because a client, upon release from the institution, may return to his home. This requires a transfer of the case to the DVR field counselor nearest the client's home. A successful closure under these circumstances will be credited to the field counselor regardless of the amount of service provided by the special counselor at the institution. Overall, mental and correctional unit counselors reported over twice as many transfers per caseload in FY 1975 (49 and 43 respectively as compared to 21 for an average general caseload). Another group of counselors who have few successful rehabilitations are counselors assigned to Social Security caseloads and, in particular, those who concentrate on clients receiving Supplemental Security Income (SSI) benefits. Of the ten general caseloads with the fewest successful rehabilitations, seven were SSI counselors. These seven counselors produced an average of only seven rehabilitations each. Interviews with SSI counselors demonstrated that SSI clients generally are severely disabled and have no work skills or experience and are considered difficult and expensive to rehabilitate.

While the variations between general and specialized counselors and between special units are major, it is important to point out that statistical measures of quantitative performance are not necessarily the best measures of counselor productivity. Quality of case work also must be recognized. For this reason, it should be made clear that a large number of rehabilitations is not necessarily or inherently "good" or "bad".

However, the heavy concentration of workload activity and expenditures in relatively few caseloads, and the concentration of active caseloads in particular geographic areas and types of programs does raise questions regarding workload distribution. The various special programs and specialty counselors represent expensive management decisions in terms of the manpower resources available to DVR. These units also tend to concentrate on intervention in cases

Table 27

WORKLOAD AND EXPENDITURE MEASURES FOR SPECIALIZED CASELOADS DURING FY 1975

Type of Caseload	Number of[1] Units	Number of[2] Counselors	Rehabilitations	Rehabilitations[3] Per Counselor	Rehabilitation[3] Rate	Total Expenditures	Expenditures[3] Per Counselor
Welfare	10	23	792	37.1	54.9%	$ 905,734	$ 42,268
Drugs	8	8	155	25.7	54.8	300,031	47,981
Schools	8	30	924	30.8	63.4	534,089	17,914
Mental Health	7	28	592	22.8	48.8	669,950	24,792
Corrections	6	16	612	38.3	57.9	229,471	14,342
Deaf	5	5	87	21.8	79.1	228,643	56,583
Other[4]	1	1	0	--	--	152,516	152,516
Subtotal	45	111	3,162	30.3	56.8%	$ 3,020,434	$ 28,518
General Caseloads	--	121	5,977	50.2	67.0%	$ 9,985,240	$ 83,868
Total	--	232	9,139	39.5	63.2%	$13,005,674	$ 58,055

[1]See Appendix 2 for Special Units.
[2]Six counselors in general offices who had a clearly specialized caseload were assigned to the appropriate type of unit.
[3]Per counselor averages were calculated based on the deletion of nine caseloads which were not active during most of FY 1975.
[4]Special spinal cord injury project at the Towers Hospital in Charlottesville.

Source: JLARC Analysis of Workload and Expenditure Data for FY 1975.

which do not have immediate vocational potential, such as students (school units) or institutionalized clients (corrections and mental health). The decision by DVR to terminate the special corrections units in FY 1976 represents a recognition that clients can be served by general counselors rather than require the commitment of 16 full-time counselors. The same is true for the drug abuse program and its nine full-time counselors. However, DVR made it clear in its budget request for the 1976-1978 biennium that it desired to retain these programs as separate special units if State funds could be obtained.

Beginning in FY 1977, approximately 25 counselors from the corrections and drug programs will be transferred to general caseloads, but about 80 other counselors will continue in specialty assignments. DVR probably should also terminate the remaining school special units and provide service to these clients through the general field offices.

Measures of Quality

A pervasive problem of the vocational rehabilitation profession has been measuring the quality and quantity of a counselor's effort in terms of the disabilities they serve and the number of clients rehabilitated. The problem became increasingly important with the Rehabilitation Act of 1973 as each State agency was forced to serve the severely disabled on a priority basis. The profession has addressed the issue by trying to develop a "weighted-closure" system whereby clients with more severe or more disabling conditions receive a higher weight in the agency's accounting system than clients with minimal or marginal disabilities. DVR has taken only preliminary steps to develop such a system. It is particularly important that efforts be accelerated since it was found that DVR has a tradition of placing counselors under pressure to rehabilitate large numbers of clients without due regard to degree of disability.

Quality vs. Quantity

Producing numbers of rehabilitated clients was formally addressed by DVR in December, 1975. At this time, a memo was issued implementing minimum activity standards for counselor performance. The memo stated:

> We are adopting these minimum standards for closures and we will use these figures after the first year of employment as the minimum acceptable level of activity. They are as follows:

Category	Minimum Number of Closures
Field	60
School	45
Corrections	30
Trust Fund	30
Mental	30
Welfare	45
Deaf	30
Drug	30

While these quotas reflect the different types of caseloads, and their unique requirements, they do not consider the greater amount of time and resources that are supposedly required to rehabilitate the severely disabled. Instead, this emphasis reflects a continuing DVR concern to maintain a high quantity of productivity on the part of counselors.

While not explicitly stated previously, it was found by JLARC that DVR does pressure counselors to produce certain numbers of successful rehabilitants. The pressure inherent in this quota system was documented in a survey conducted by the DVR Board during the fall of 1974. Of 190 field counselors surveyed, over 90% either agreed or strongly agreed with the statement:

- Counselors and supervisors have felt undue pressure to produce 26's (successful closures) during the past several years.

This finding was further confirmed in their response to another statement:

- The quality of casework practice has been secondary to an emphasis upon the quantity of cases that one should process.

Again, over 85% of the general field counselors either agreed or strongly agreed that quality was secondary to quantity.

Further evidence of pressure to produce large quantities of rehabilitated clients is reflected in case audits by supervisors. These reviews generally assess the way counselors are performing the compliance aspects of their job. However, JLARC did find production to be stressed. For example, one counselor was asked to review his decreased production over a two-year period.

> Your particular caseload has had decreased activity over the last two years. If you note in 1973, you were considerably ahead at this time...I mention these facts that you may be alert to this downward trend, as no doubt you are and analyze what is causing this to happen....it would be good for you if you can consider objective ways to reverse this particular trend.

Another counselor was confronted with activity for one year and asked to correct deficiencies in three months time.

> Through the end of April (1975) you had received 212 referrals, accepted 65 cases, initiated 48 plans, and closed 32 as rehabilitated. Comparing your plans initiated to your referrals, you are providing service to less than 25%. The reason these people come to us is that they want services, as a result of this evaluation, there are many who have a substantial disability and need VR services. I feel that you are going to have to make a tremendous improvement in the delivery of services. By July 31st, I must see a substantial improvement in your production activity. By this I mean that I would like a minimum of 10 plans initiated per month between now and July 31st.

Minutes of Regional Directors and Supervisors meetings also reflect emphasis on quantity. While it was stated that it was important to provide quality of case services, it was also made clear by a department official that activity would be monitored in reference to possible job cuts.

> If you want to be sure you have a job be sure you are in good standing as far as activity is concerned. If you are effective in what you are doing, you won't have any concerns about your job.[8]

During JLARC's counselor interviews, it was pointed out that while no one could be identified as fired because of not meeting production goals, counselors feel considerable pressure to enhance job success. Counselors did express the opinion that this pressure was contradictory to DVR's goals to serve the severely disabled. Also, while most counselors interviewed indicated that they still felt pressure to close clients as successfully rehabilitated (68 out of 94 interviewed), there were some indications of less pressure now than in the past.

The quota system has been rationalized by DVR counselors to a certain degree. Several counselors stated that the reason for successfully rehabilitating large numbers of clients is that states with large proportions of closures receive a greater allotment of available federal funds. However, JLARC found little to substantiate this claim. Federal aid funds for vocational rehabilitation are distributed on the basis of state population and per capita income. In the past, it was possible for a state whose need exceeded budgeted case service funds to obtain surplus funds made available from other states at the end of each fiscal year. Only in this sense could production be related to funding.

Other reasons given for supporting the quota system were that by being a high producer a counselor had a better chance at promotions in addition to receiving more respect. Regardless of how the system is used, it emphasizes quantity and not the quality of service. Until it can incorporate appropriate qualitative features, its purpose will be limited to activity descriptions.

Quota Implications. The results of the quota system are clear in considering the types of clients who will be served if pressure is exerted to arrive at just a large number of rehabilitated clients. JLARC found that, in approximately a third of all cases claimed as rehabilitated in FY 1975, there was little or no evidence of client benefit. This category was best represented by cases in which eligibility criteria were stretched to include an ill-defined disability, minimal services were provided (75% of these cases had $100 or less spent on them), and there was generally little counselor contact. An example would be:

Case Number 5-1

> *A client referred from the work release program of the Department of Corrections, received about $100 worth of work clothing and shoes from DVR. The client had no evidence of counseling or guidance being provided by DVR, and job placement was through the corrections program.*

Conclusion

The quota system used by DVR encourages counselors to emphasize the quantity of successful closures even though the clients served may be only minimally disabled. This is unfortunate as a quota system could serve as a useful management tool provided consideration is given:

- the type of disabilities served by each counselor;
- the distribution of severely disabled or other priority service individuals in relation to all others; and,
- the degree to which a caseload is comprised of clients whose handicap is more substantial than others.

It is ironic that with the mandate to serve the severely disabled already established, DVR in December, 1975, issued a memorandum implementing minimum activity standards for counselor performance. The pressure to keep production at either minimum levels or at even higher rates is taken as evidence that DVR has no serious intention of altering the quota system to include the severity of the clients' disabilities. Furthermore, some counselors expressed the opinion that if you meet a quota this year, then next year it will be increased. Thus, while minimum standards could be viewed as a desirable feature of a structured goal system, they appear to be dysfunctional in the way that DVR has used them. Accordingly, JLARC recommends that DVR implement a weighted closure system as soon as possible. This system should include, as a minimum, the three measures of quality listed above.

Agency Self-Evaluation

A principal way in which DVR has addressed the need for self-evaluation is through the establishment of a Program Evaluation Unit as part of the Division of Program Planning and Development. The 1973 Rehabilitation Act increased accountability requirements of State agencies by establishing standards "for evaluating program effectiveness, for increasing program accountability, and for encouraging State vocational rehabilitation agencies to conduct more comprehensive evaluation of their programs". The RSA developed standards designed to address four accountability issues:

- Impact on the target population.
- Degree of change in reaching gainful activities goals through rehabilitation services.
- Program performance in meeting the priority for providing services to the severely handicapped.
- Effectiveness of the program in utilizing available resources.[9]

Application of these standards require the accumulation of 39 data elements. The RSA will use centrally reported statistics to measure performance on 25 of the elements and has required each agency to report on the other 14.

The standards are based on FY 1973 aggregated national data, and each agency is measured against their FY 1974 performance. A key aspect of each agency's reporting responsibilities is the design of client follow-up methods.

Because a few states were already doing follow-up studies on a routine basis, RSA avoided setting performance levels in this area but required, as a minimum, the states come up with a plan for measuring client outcomes. In the case of Virginia, DVR's new evaluation unit has begun a follow-up of all successful and unsuccessful rehabilitants closed in FY 1975.

Additional areas of responsibility for DVR's Program Evaluation Unit are:

1. Evaluation of cooperative programs to determine the extent to which the programs have achieved defined goals.

2. Evaluation of special projects and grants.

3. Review of State Plan commitments.

4. Review of specific programs identified through agency priorities.

5. Assess agency activities that are desired by the Commissioner.

The Program Evaluation Unit also supervised an audit of open and closed cases on a task force basis. This approach could have wide implications for improving the quality of case audits if compliance review aspects are de-emphasized in favor of:

- Program rather than technical eligibility.
- The adequacy of the casework planning process.
- The appropriateness of service in relation to the disability.

Finally, a needed reform to the present case audit system is an independent judgment of whether the client benefited from the services received and thus enhanced his employability.

Conclusion

The lack of a fully developed and comprehensive priority system has limited DVR's management of the client acceptance process. Counselors do not use a selection procedure that identifies the relative priority of the wide range of clients that are eligible. In addition, it was found that half of all clients have no priority assignment. Finally, the existing priority system is disability-based and this prevents other goals from being addressed. DVR should develop a new priority system that would have General Assembly review and approval.

This review found that weak controls exist over counselor spending. The rate of spending is not controlled and this generally led to a budget crisis

in FY 1976 in which the majority of all case service funds were spent or encumbered with more than half the year remaining. Supervisors do not use a standardized set of controls over counselor expenditures. Also, it was found that counselors could overspend their allotment for case services. This lack of control, given the more constrained financial circumstances of the agency, requires immediate management attention. There are signs that DVR is beginning to address some of these financial management areas. For example, they are now encouraging counselors to seek out third-party sources of funding.

A redirection of effort is required in the special units which serve clients of mental hospitals, schools, welfare units, drug units, and corrections facilities. In FY 1975, 45% of all counselors were assigned to these special units. This represents an expensive decision since these counselors generally serve and rehabilitate fewer clients than other counselors. The elimination of the corrections and drug units was a good decision since clients in these units do not routinely have severe disabilities. JLARC additionally recommends that units at specific school units be terminated. This should make approximately 44 counselors available and their redistribution should be aimed at serving clients with the most severe disabilities.

In order to ensure a greater degree of control over counselor decisions, the program and unit supervisors should be delegated more authority. Case audits need to be directed away from compliance reviews and in the direction of program impact. DVR is experimenting with a new case audit system which could improve the quality of case audits if the system can monitor eligibility, effectiveness of case planning, and assess appropriateness of service. Finally, the supervisors need to frankly judge whether the client benefited from the services received.

A tradition of placing counselors under pressure to rehabilitate large quantities of clients needs change. This pressure has made the quality of each rehabilitation secondary to the quantity of clients that are produced. In terms of clients served, this system often results in clients with minimal disabilities being served first. DVR needs to adopt and use qualitative measures for each rehabilitation.

Finally, an expanded role for the Program Evaluation Unit may be a key factor in resolving many of the difficulties facing DVR. If this unit can manage case audits and orient them in the direction of critical judgments and client benefits, a major improvement can be brought about.

Vocational rehabilitation serves an important public function. Central to its purpose is a humanitarian interest in restoring the disabled individual so that he or she may be able to work again. However, as a public function, there needs to be a wise use of the limited federal and State funds that are available. A special effort is required to manage these resources so that the Commonwealth can obtain the best results possible.

VIRGINIA COMMISSION FOR THE VISUALLY HANDICAPPED

Vocational rehabilitation is only one of many services that the VCVH makes available to the Visually handicapped. While the Commission uses the same eligibility definition as DVR, they put less emphasis on vocational potential; and, as a result, only one-third of VCVH clients are placed in a wage-paying job. In 1975 the Commission's vocational rehabilitation program served 3,233 clients and rehabilitated 643.

Most Commission clients are severely disabled with over half being legally blind. In addition, VCVH clients are considerably older than the average rehabilitation client with 13% of all 1975 rehabilitants 65 or older at referral. In most cases the vocational rehabilitation program provides either surgical or medical treatment, or underwrites the cost of training designed to help the visually impaired person adjust to his or her handicap. In providing service to clients the Vocational Rehabilitation Department works closely with other departments of the Commission--particularly the Rehabilitation Teaching Services Department--which actually provide much of the training. The responsibilities of vocational rehabilitation personnel are defined in an intra-agency cooperative agreement.

The Commission receives funding support for vocational rehabilitation from the federal government under the 1973 Rehabilitation Act. Through an agreement with DVR, the Commission receives a fixed 12½% of Virginia's federal aid allotment for vocational rehabilitation. This totaled $2.7 million in FY 1975 which was about 37% of the Commission's revenue.

This chapter reviews the Commission's vocational rehabilitation program and the long term benefit for a sample of those persons who obtain wage-paying jobs. Not all visually handicapped persons who need rehabilitation are served and there is evidence that an adjustment in priorities and an improved outreach effort are needed in order to make maximum use of available resources.

VI. VIRGINIA COMMISSION FOR THE VISUALLY HANDICAPPED

The Virginia Commission for the Visually Handicapped (VCVH) operates a vocational rehabilitation program as one aspect of its overall service delivery system for the blind. This program serves half of all Commission clients and provides over 40% of all VCVH revenues through federal aid funds. While the vocational rehabilitation program of VCVH and that of DVR have many similarities, there are also substantial differences. Primary differences occur in program management. Additionally, VCVH generally deals with an older, more severely disabled client population which is often characterized by limited vocational potential. To serve these clients VCVH has adopted a much more liberal interpretation of federal law than has DVR.

In evaluating the VCVH vocational rehabilitation program, JLARC interviewed Commission personnel and reviewed various records. JLARC also reviewed a sample of 10 case files which, while not generalizable due to sample size, does offer an overview of VCVH activities. In addition, an employment follow-up of VCVH clients was conducted. A description of the sample is included in the Technical Appendix.

Eligibility and Service Delivery

VCVH was established as a State agency in March, 1922, to provide comprehensive services to the legally blind and partially sighted residents of the Commonwealth. The Commission has the authority and responsibility under the *Code of Virginia* to provide a number of services which include: acting as a bureau of information and industrial aid, maintaining a register of the blind, making inquiries concerning the cause and prevention of blindness, establishing schools and workshops for the blind, operating a library service for the handicapped, assisting the blind in finding employment, and teaching them job skills which may be followed in their homes.

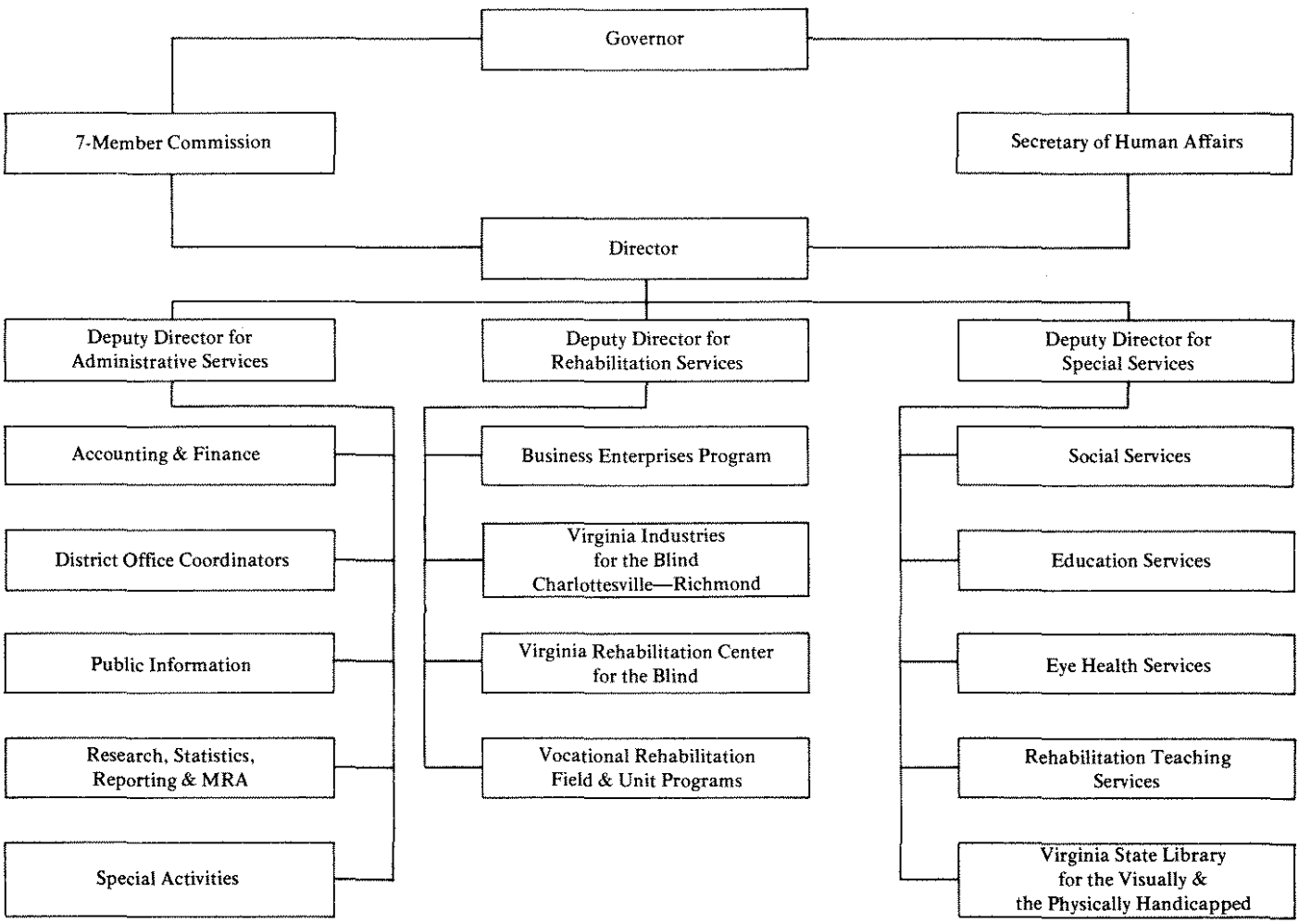
Vocational rehabilitation is only one of the functions of the Commission. It, however, is not provided to all clients (approximately 48% of all active clients receive vocational rehabilitation services). Organizationally, vocational rehabilitation service programs are administered by one of three Deputy Directors and include the activities of the vocational rehabilitation field program, the Virginia Industries for the Blind workshops at Charlottesville and Richmond and the business enterprises program. The organization of the Commission is shown in Figure 12. In 1975 vocational rehabilitation services were provided by 18 counselors located in Alexandria, Bristol, Norfolk, Richmond, Roanoke, and Waynesboro. The vocational rehabilitation program served 3,233 persons and rehabilitated 643 in FY 1975.

Eligibility for VCVH Rehabilitation Services

The VCVH vocational rehabilitation program serves persons who are blind or visually impaired as defined in a cooperative agreement between DVR and VCVH. According to the agreement, VCVH clients are persons who are blind, whose vision impairment exceeds a standard measure of severity (generally 20/200 corrected in the better eye and/or a 20-30 degree loss in the visual field), who have been unable

Figure 12

VIRGINIA COMMISSION FOR THE VISUALLY HANDICAPPED



Source: Virginia Commission for the Visually Handicapped, *Annual Report*, 1973-74.

to adjust to a loss of vision, or who will require eye treatment or surgery. Persons meeting these criteria but who are already a client of DVR may be provided with rehabilitation services by DVR rather than transfer an open case between the two agencies. Beyond these agency designated criteria the prospective client must meet the three basic eligibility criteria of, (1) disability, (2) substantial handicap, and (3) reasonable expectation of employment if federal rehabilitation funds are to be used.

While both DVR and VCVH operate under the eligibility standards of the 1973 Act there is a distinct difference in the way each agency determines eligibility. DVR stresses the vocational aspect of its program and concentrates service on those clients who can be placed in competitive wage-paying employment. VCVH emphasizes services which may assist the individual in adjusting to their

disability but may not result in a wage paying job. As a result DVR clients achieved competitive employment in 77% of all FY 1975 cases while VCVH closed only 34% of all cases competitively. Both approaches satisfy the existing federal eligibility guidelines; however, VCVH's interpretation is as broad as can be justified within the context of vocational rehabilitation. Table 28 shows the proportion of FY 1975 rehabilitants that were closed in various employment categories including competitive employment.

Table 28

TYPE OF EMPLOYMENT AT CLOSURE
FY 1975 REHABILITANTS OF DVR AND VCVH

	DVR		VCVH	
Type of Employment	Number	Percent	Number	Percent
Competitive Wage or Salaried	7,027	76.9%	216	33.6%
Sheltered Workshop	201	2.2	18	2.8
Self-Employed - Business Enterprise Program	274	3.0	23	3.5
Homemaker	1,557	17.0	289	45.0
Unpaid Family Worker	80	.9	97	15.1
Total	9,139	100.0%	643	100.0%

Source: DVR Summary of Case Service Reports, FY 1975, and Clients Statistics-VCVH.

Nature of the VCVH Client

The vocational rehabilitation program of VCVH provides service to a substantially different client than does DVR. The majority of VCVH's clients are severely disabled when accepted (87% compared to about 25% for DVR) with over half (56%) being legally blind. Clients of VCVH that are not severely disabled generally need eye surgery or treatment but have not suffered enough sight loss to be categorized as severe. The rehabilitation clients of VCVH are considerably older, on the average, than DVR clients. Almost two-thirds of FY 1975 rehabilitants were 45 years of age or older with 13% being at least 65. A number of FY 1975 rehabilitants were in their 80's and one client was 91. The use of vocational rehabilitation funds for services to clients over 65 years of age also reflects a very liberal interpretation of the federal law since such individuals normally have limited vocational potential. Table 29 shows the age distribution for VCVH and DVR rehabilitation clients in FY 1975.

Another major distinction between the two agencies is the likelihood of a successful rehabilitation. While DVR rehabilitated 63% of all eligible clients in FY 1975, VCVH was able to rehabilitate 88% of all 1975 eligible cases. This high success rate is probably due to a combination of factors including VCVH's more extensive use of employment categories such as homemaker and unpaid family worker, client age, and the ability to VCVH counselors to keep track of their generally less mobile clients.

Table 29

AGE OF REHABILITATED CLIENTS
VCVH AND DVR, FY 1975

Age at Referral	DVR Number	DVR Percent	VCVH Number	VCVH Percent
Under 20	2660	29.1%	47	7.3%
20 - 34	3541	38.8	126	19.6
35 - 44	1332	14.6	72	11.2
45 - 64	1575	17.2	313	48.7
65 and over	31	.3	85	13.2
Total	9139	100.0%	643	100.0%

Source: DVR Summary of Case Service Reports, FY 1975, and Client Statistics-VCVH.

Service Delivery

VCVH rehabilitation counselors provide two primary types of service to their clients: (1) surgery, hospitalization and treatment for eye conditions, and (2) training designed to allow a client to adjust to his or her disability. The latter is generally referred to as independent living training. Examples of these two types of case services are described below:

Medical Treatment in the form of surgical, hospitalization, or prosthetic services was provided to about 663 clients in 1975 at a cost of $397,372. For example:

Case Number 6-1

> *A 21 year old male was referred to VCVH from DVR because of a diagnosis of cataracts which would require surgery. VCVH paid $927 for surgery and the purchase of a contact lens to correct the client's binocular vision. The client was then closed as a feedmill worker earning $2.15 per hour.*

Case Number 6-2

> *A 55 year old male was disabled by the loss of an eye. The client was employed at referral with a monthly income of $486. Case notes indicate that he lost his prosthetic eye and requested that VCVH provide a replacement. The client was declared financially eligible and VCVH paid $125 for the prosthesis. The client was closed as rehabilitated when he returned to his regular job.*

Independent Living Training is VCVH's other major service option. This training is available through the Virginia Rehabilitation Center for the Blind (VRCB), two week programs sponsored in various locations around the State, or by home visits of the rehabilitation counselor.

The vocational rehabilitation program of VCVH plays a supportive role by providing independent living training, since it primarily underwrites the cost of these various training programs. Vocational rehabilitation funds are used to pay per diem expenses at VRCB, to purchase room and board for clients who attend the two week programs, and to purchase various training aids, specialized equipment, and low cost medical items (glasses or general medical examinations). For example:

Case Number 6-3

> *A 57 year old female was severely disabled by failing vision due to diabetes. Services were provided by both a counselor and a VCVH rehabilitation teacher. Based on the case file, it appears that the actual training was done by the rehabilitation teacher with the counselor providing reading glasses and a low vision aid package at a cost of $83. The client was closed as a homemaker.*

Case Number 6-4

> *A 73 year old female was disabled by failing eyesight compounded by arthritis and hypertension. The disability appeared to be progressive and her age obviously limited her vocational potential. She was a client of both vocational rehabilitation and the rehabilitation teaching service of VCVH. Vocational rehabilitation purchased a general medical exam for the client at a cost of $18. The counselor followed the case closely for over a year and a half. However, no other services appear to have been provided. The client was closed in self-employed work making handicrafts at an income of $10 a week.*

The two week training programs are sponsored for clients in need of independent living training but who, for some reason, cannot attend the Rehabilitation Center in Richmond. Vocational rehabilitation will pay for maintenance of clients at these programs. For example:

Case Number 6-5

> *A 59 year old female was disabled by eye trauma and atrophy of the optic nerve. She was provided with room and board for two weeks at Virginia Beach in order to attend a rehabilitation teaching course. In addition, VR purchased a set of special kitchen utensils. The total cost of the case was $242. The client was closed as a homemaker.*

In addition to surgery or independent living training VCVH provides some vocational training. In FY 1975, over 120 clients were provided with post-secondary academic training, and 64 clients received on-the-job training. However, vocational training was provided to less than 7% of all active clients in FY 1975 which emphasizes the low utilization of this service option.

Meeting the Need for Services

Although VCVH has rehabilitated 4,616 persons in the last ten years, it has not met the needs of all eligible handicapped persons. A reasonable estimate of the eligible work age population using VCVH's estimating formula indicates there are 5,778 eligible visually handicapped persons, age 15 to 64, in the State at any given time. Using this same formula, it is estimated that 183 newly eligible persons enter this group every year. Thus, there are probably 2,980 eligible persons in the State who were not served for the period 1966-1975. Figure 13 shows the incidence estimates graphically.

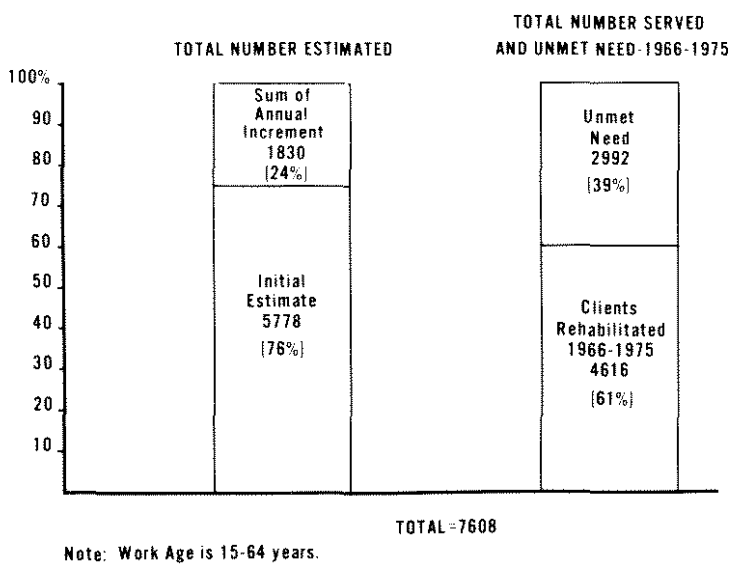
There is evidence of an unmet vocational rehabilitation need which should probably take precedence over the provision of vocational rehabilitation services to persons whose potential is limited by age as well as by disability. The VCVH rehabilitation program should prioritize acceptance and outreach efforts to find and rehabilitate those unserved clients in the conventional work age population who have immediate potential for entering the labor force with the aid of vocational rehabilitation services.

Program Costs

The vocational rehabilitation program of VCVH is funded primarily with federal monies under the 1973 Rehabilitation Act. The Act requires that a single State agency be named to receive federal aid funds, but states have the option of passing some portion of the funds through to an agency for the blind. Currently 25 states have such a separate agency for the blind. Under this

Figure 13

ESTIMATES OF VCVH UNSERVED WORK-AGE POPULATION
FY 1966-1975



Source: JLARC Analysis of Statistics and Estimating Formula of VCVH.

arrangement VCVH receives 12½% of Virginia's general aid for vocational rehabilitation funds along with 15% of the SSI funds and 13.6% of the SSDI funds. These percentages are not federally mandated but are arrived at by agreement between DVR and VCVH.

Table 30 shows the total revenues and the revenues of the vocational rehabilitation program received by VCVH since FY 1973. As shown, vocational rehabilitation revenues represent a substantial and growing portion of all VCVH revenues.

Table 30

VCVH REVENUES FY 1973-1975

Year	Vocational Rehabilitation (State)	Vocational Rehabilitation (Federal)	Vocational Rehabilitation Total	VCVH Total	Vocational Rehabilitation as a Percent of Total
FY 1973	$450,470	$1,756,155	$2,206,625	$6,146,159	35.9%
FY 1974	430,756	2,018,048	2,448,804	6,722,590	36.4
FY 1975	527,353	2,694,825	3,222,178	7,356,541	43.8

Source: VCVH *Annual Reports*, FY 1973-1975 and SRS-RSA-2, FY 1973-1975.

Most expenditures were made for services to individual clients (48.5%) with administration (14.6%), counseling and placement (12.5%), and other expenditures (24.4%) accounting for the remaining funds. Figure 14 shows the distribution of expenditures just for service to clients.

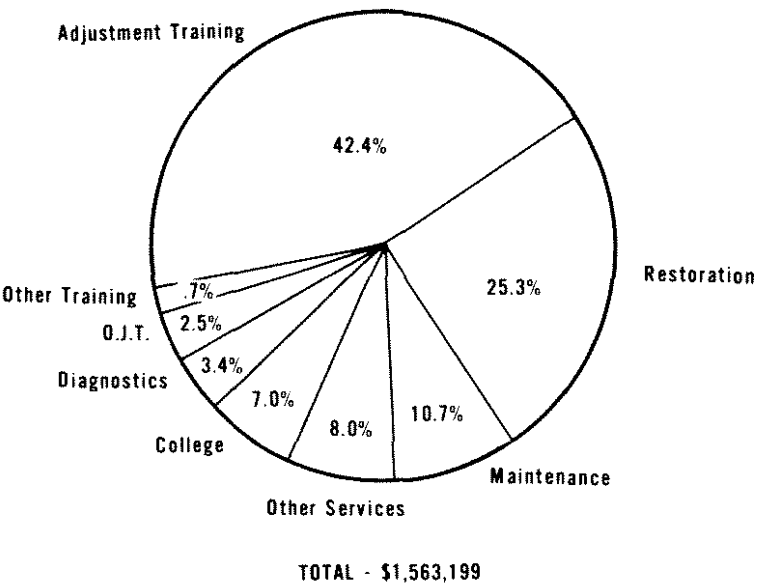
VCVH rehabilitations are generally expensive with average costs of $1,004 in 1975 if expenditures were required. Fifty-five of VCVH's 643 reported rehabilitations (8.6%) did not require expenditure. The average cost for all rehabilitations was $919 compared to DVR's average per case cost of $674. The higher cost of a VCVH rehabilitation is due to the greater proportion of severely disabled clients, particularly the legally blind who averaged $1,115 for 331 cases in 1975.

SERVICE IMPACT

An employment follow-up of VCVH clients was conducted as part of the JLARC review. This follow-up addressed two issues: (1) have clients of the vocational rehabilitation program who were closed in competitive wage paying employment maintained that employment, and (2) what kind of income can clients expect. To conduct the follow-up JLARC obtained employment information on a sample of 116 clients who were successfully rehabilitated into competitive employment during FY 1974 and FY 1975. This is the same method as used with DVR clients. Employment information was available for 74 of the 116 sampled cases (64%) and covered a period from July 1, 1974 through October 31, 1975. A complete description of the sample is included in the Technical Appendix.

Figure 14

EXPENDITURES FOR SERVICE TO INDIVIDUALS
FY 1975



Source: Virginia Commission for the Visually Handicapped, FY 1975, (SRS-RSA-2).

Short Term Attrition. Of the 56 cases closed in FY 1975, 26 had an employment record on file with the Virginia Employment Commission (VEC). No information was reported on the remaining 30 clients after closure. They may have been employed in jobs not covered by the VEC file. Where information was available, it was found that 58% (15) of the 26 cases were employed continuously and, therefore, had succeeded in maintaining their employment over the short term (at least 6 months but not more than 15 months). Six clients dropped out of employment during the test period while five clients became employed or were reemployed despite some gaps in their employment records.

The short term follow-up finding that 77% (20) of 26 clients had evidence of either continuous employment or reemployment is favorable. Evidently, many VCVH clients who have been closed from the vocational rehabilitation program manage to retain their employment for from six months to over a year after closure. This finding is particularly good since 10 of 15 clients who were employed all possible yearly quarters were severely disabled.

This finding is somewhat offset by the 30 cases which had no VEC employment history after closure, particularly since there were 10 cases who were employed prior to being closed, but not on the file after being successfully rehabilitated. Since the VEC files cover about 80% of the State's wage or salaried jobs, the miss rate for the VCVH sample is high. However, evidence of temporary benefit was found in the case file review. For example:

Case Number 6-6

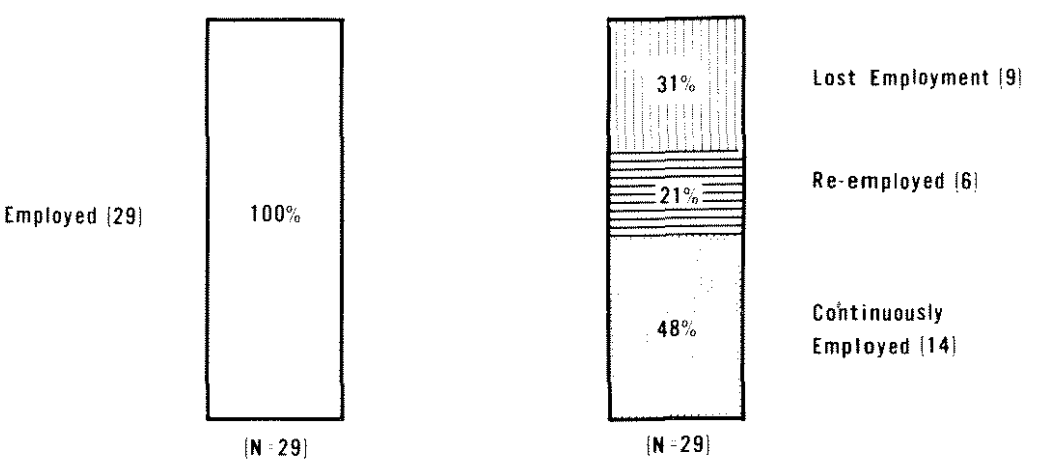
> *A 16 year old legally blind male was referred to VCVH with a congenital visual impairment. The client had dropped out of school after the 9th grade. School officials considered him to be a behavior problem. VCVH provided adjustment training at the Virginia Rehabilitation Center for the Blind and also vocational evaluation and training at Woodrow Wilson at a total cost of $616. The client obtained a job as an X-ray technician in September, 1974, and was closed as rehabilitated in February, 1975. The client held this job until June, 1975, when he was fired. The client then worked as a mechanic's helper until December, 1975, when he again became unemployed and applied for SSI benefits.*

Long Term Attrition. JLARC used a sample of 60 clients successfully rehabilitated in FY 1974 to assess long term job retention. Long term retention was defined as evidence of stable employment for at least 15 consecutive months after closure. Figure 15 shows the results of the long term follow-up.

As shown, only 14 clients retained their employment through all 15 months. When reemployment is included (reemployed clients were not continuously employed but were working at the end of the test period) the total of employed clients is 20 as compared to 29 who were employed 15 months earlier. This is a 31% attrition rate for clients with data available. This finding is again essentially favorable since almost 70% of the clients for whom data is available stayed employed. Also, 70% of the clients who stayed employed were severely disabled.

Figure 15

LONG TERM ATTRITION



Source: JLARC Employment Follow-Up Study.

Measures of Client Income. In addition to levels of employment, the client's income was used as a measure of the impact of the VCVH vocational rehabilitation program. Most rehabilitated clients have low incomes which averaged only $4,420 per year over the short term and $5,512 per year for clients who maintain stable long term employment. Table 31 reflects the distribution of average incomes for clients who either had evidence of continuous employment or reemployment.

Table 31

ESTIMATED ANNUAL INCOME FOR VCVH CLIENTS
WITH CONTINUOUS EMPLOYMENT OR REEMPLOYMENT

Average Yearly Income	FY 1975 (short term) Continuous Employment	FY 1975 (short term) Reemployment	FY 1974 (long term) Continuous Employment	FY 1974 (long term) Reemployment	Total
Less than $1000	1	0	0	2	3
$1000 to $2000	3	1	0	0	4
$2000 to $4000	4	0	4	1	9
$4000 to $8000	5	4	8	2	19
Over $8000	2	0	2	1	5
Average per year	$4,420	$5,184	$5,512	$4,444	$4,900
Base:	(15)	(5)	(14)	(6)	(40)

Source: JLARC Employment Follow-Up Study.

The table shows that those clients who were closed in FY 1974 and who experienced continuous employment had a slightly higher income both in terms of average per year earnings and in the proportion of clients whose earnings fall in the higher brackets. Overall, however, the average annual income which can be expected for clients indicates that many VCVH rehabilitants do not become economically independent, particularly those clients who earn less than $4,000 annually.

Conclusion

The majority of clients for whom data were available did stay employed both in the short and long term samples. The 31% who dropped out of employment over the long term probably represent a good estimate of what can be expected for long term attrition (within 2½ years after closure) among VCVH clients who are closed in competitive jobs.

Overall, it is evident that VCVH's rehabilitation program provides economic benefit to disabled clients. The income levels are low, which indicate that many clients cannot become economically independent even if they succeed in staying employed. However, most of the VCVH clients, including those who are rehabilitated in competitive employment, are severely disabled. As previously shown, the severely disabled served by DVR tend to do better than those of VCVH in terms of levels of employment and income. However, the employment follow-up

results are not unexpected and indicate a fair degree of success for those clients who find competitive employment. VCVH does need to increase the proportion of their rehabilitants who become competitively employed through increased placement efforts and an increased effort on behalf of clients with greater vocational potential.

END NOTES

Chapter 1 - INTRODUCTION

1. JLARC relied on six surveys of disabled persons for this data; the National Center for Health Statistics (*Health Interview Survey*), Bureau of the Census, Social Security Administration (*Survey of Disabled Adults*), the Ohio State University, the Governor's Study Commission on Vocational Rehabilitation, and the Urban Institute. The total disabled in the State ranged from 531, 275 (Governor's Commission data updated to 1977 by DVR) to 534, 131 (Urban Institute data as used by DVR). The number eligible is drawn from the 1977 update of the Governor's Commission study. This data is old (1968) and drawn from a narrow sample base. A new study should be conducted which is more generalizable.

2. U. S., General Accounting Office, *Effectiveness of Vocational Rehabilitation in Helping the Handicapped*, April, 1973, pp. 44-45.

Chapter II - NEED, REFERRAL, AND ELIGIBILITY

1. U. S., Congress, *PL 93-11*, Section 101 (a) (15).

2. U. S., General Accounting Office, *Effectiveness of Vocational Rehabilitation in Helping the Handicapped*, April, 1973, B-164031(3), and *Administrative Study of the Virginia Department of Vocational Rehabilitation*, The Final Report of Finding and Recommendations on Phase II. (Boston: Harbridge House, Inc.) 1965.

3. The problem of referrals who refuse service is compounded by a problem with the way in which SSA administers the disability program. Counselors are required to report disposition of each case to Social Security--whether it was accepted or rejected and particularly to inform the SSA if a client refuses services which could reduce or eliminate his dependence on benefits. If a client refuses service, Social Security may terminate if refusal was not justified. This regulation has not been enforced by the SSA although there is evidence that increased enforcement may be expected in the future. A memo to all DVR, SSDI, and SSI counselors (February 10, 1976) reported that RSA has recently informed all State offices and agencies that this provision is not being enforced. The RSA has found that a high percentage of cases which should have been forwarded to the Social Security district office were not. As a result, counselors were reminded to make increased efforts to report all refusals of service in the future. While the fault for not enforcing SSA regulations is federal, DVR should continue to report refusals of VR services to the SSA as a means of encouraging disability benefit recepients to accept VR services.

4. U. S., *Code of Federal Regulations*, Title 45, Section 401.1(bb).

5. U. S., Department of Health, Education and Welfare, Philadelphia Regional Office, *Review of the Vocational Rehabilitation Program Administered by the Department of Vocational Rehabilitation, State of Virginia*, Audit Control Number 60302-03 (Philadelphia, November, 1975).

6. U. S., Department of Health, Education and Welfare, Social and Rehabilitation Service, Rehabilitation Service Unit, Region III, *Program Administrative Review of the Vocational Rehabilitation, State of Virginia*, (Philadelphia, January, 1975).

7. Most of these mild disabilities were named by RSA in their memorandum to Department of Health, Education and Welfare, Office of Human Development, Rehabilitation Services Administration, Memorandum: *Services to Clients with Insubstantial Employment Handicaps: Selected Disability Conditions of Clients Rehabilitated in Fiscal Year 1973*, November 7, 1975.

8. U. S., Department of Health, Education and Welfare, Office of Human Development, Rehabilitation Services Administration, Memorandum: *Services to Clients with Insubstantial Employment Handicaps: Selected Disabling Conditions of Clients Rehabilitated in Fiscal Year 1973*, November 7, 1975.

9. Ibid.

10. Second Institute on Rehabilitation Issues, *The Delivery of Rehabilitation Services*, (Menomonie, Wisconsin: Research and Training Center, University of Wisconsin - Stout, 1975), p. 92.

11. JLARC conversation with a Vocational Rehabilitation Program Specialist, Office of Human Development, Rehabilitation Services Administration, January 6, 1976.

Chapter III - SERVICE PROVISION

1. As a part of its evaluation, JLARC conducted a survey of the vocational rehabilitation programs of neighboring states. States contacted were West Virginia, North Carolina, South Carolina, Pennsylvania, and Maryland. Officials were asked about agency procedures for administering the financial needs test, standards for use in determining exemptions on income and the value of real and personal property, and documentation required for client statements made regarding income and assets. In addition, information was gathered on the types of exceptional exemptions which could be allowed and the supervisor's role in the determination of financial need.

2. U. S., *Code of Federal Regulations*, Title 45, Section 401.46(3)(b)(1).

3. U. S., Department of Health, Education and Welfare, Rehabilitation Services Administration. *Program Regulation Guide*, RSA-PRG-76-8, October 15, 1975.

4. Second Institute on Rehabilitation Issues. *The Delivery of Rehabilitation Services*, Menomonie, Wisconsin: Research and Training Center, University of Wisconsin - Stout, 1975, p. 102.

5. JLARC contact with Virginia Statewide Coordinator, National Association for Retarded Citizens, March 31, 1976.

6. Virginia, Department of Vocational Rehabilitation, *Counselor Procedure Manual*, Section 6.11.

7. Department of Vocational Rehabilitation response to an Urban Institute Questionnaire, "Questionnaire for State Vocational Rehabilitation Agencies on the Usage of Similar Benefits in Vocational Rehabilitation." OMB #85-S-75043, July, 1976.

8. U. S., Department of Health, Education and Welfare, Office of Human Development, Rehabilitation Services Administration. *State Vocational Rehabilitation Agency: Program Data, Fiscal, 1974.* (Washington, D.C.: DHEW, 1975), p. 35.

9. The case files reviewed by JLARC showed that 60% of the cases costing under $100 had expenditures for diagnostics only.

10. Virginia, Department of Vocational Rehabilitation. "Presentation for the Governor and His Budget Advisory Committee." (Richmond, October 9, 1975).

11. Virginia, Department of Vocational Rehabilitation. *Counselors Procedures Manual.* Section 6.4.

12. Ibid., Section 6.51.

13. Virginia, Department of Vocational Rehabilitation. Memorandum: "Memorandum of May 24, 1974 by HEW Audit Team," (from Don Russell, Commissioner of DVR to Seth Anderson, Regional Commissioner, RSA), July 16, 1974.

14. Second Institute on Rehabilitation Issues. op. cit., p. 123.

15. Ibid., p. 125.

Chapter V - MANAGEMENT

1. U. S., Department of Health, Education and Welfare, Office of Human Development, RSA. *"Rehabilitation Services Manual Transmittal, Order of Selection, Priority, and Outcome and Service Goals."* June 23, 1975.

2. U. S., Department of Health, Education and Welfare, Office of Human Development, RSA. *"Expanding and Improving Services to the Severely Disabled"*, June, 23, 1975.

3. Virginia, Department of Vocational Rehabilitation, *"MAPS - The Agency Management and Planning System"*, January, 1976, p. 1.

4. Virginia, Department of Vocational Rehabilitation, *"Career Development and Job Enrichment Program"*, December 18, 1975, p. 1.

5. Ibid., p. 2.

6. The Department of Vocational Rehabilitation reports 200 man-years were expended in FY 1975 in their annual report to RSA. However, data is not maintained which would make these counselors comparable among regions or among special and general units. Accordingly, JLARC used active caseloads in which a counselor served for a major portion of the year for this analysis.

7. JLARC used the 1970 U. S. Census definition of urban in which only the State's cities as well as Arlington and Fairfax counties are classified as urban.

8. Virginia, Department of Vocational Rehabilitation. Minutes, "Region 1 Supervisors Meeting," January 21, 1975.

9. U. S., *Code of Federal Regulations*, Title 45, Chapter IV, Part 410 (part 1370).

GLOSSARY

Case Service Expenditure	Those payments made directly for client services, excluding the cost of counselor time and administrative overhead.
Comprehensive Service	The provision of all services necessary to achieve a rehabilitation including medical treatment, training, therapy, maintenance and job placement.
Disabled Individual	Any person who has a physical, mental or emotional abnormality which results in limitation.
Eligible Closure	Any case which was found to be eligible for service and was subsequently terminated either as rehabilitated or not rehabilitated.
Physical Restoration	Medical or medically related services including surgical, physician or dental treatment, hospital or convelescent care, or the provision of an artificial limb.
Prevocational Training	Training which is remedial in nature or which is needed to assess the handicapped individual to adjust to disability.
Prosthesis	An artificial device to replace a missing part of the body.
Rehabilitation Rate	The proportion of all eligible cases which are successfully rehabilitated.
RSA	Rehabilitation Services Administration. Agency under HEW which is responsible for administering vocational rehabilitation at the federal level.
Vendors	Any outside source from which DVR purchases services for clients.
Visually Handicapped	Blindness or significant visual impairment.
Vocational Rehabilitation	The process of restoring an individual's ability to enter or retain employment consistent with his capacities and abilities.
Vocational Training	Training which is directly related to employment such as vocational school, college or business school.

APPENDICES

TECHNICAL APPENDIX

To supplement information supplied from the Department of Vocational Rehabilitation, JLARC carried out four special studies as part of its review. One assessed employment of previously closed clients. Another consisted of a review of a sample of client casefiles. A third involved a phone follow-up of some of those whose files were reviewed. A final survey consisted of personal interviews with 98 counselors and 28 field supervisors located across the State. A basic description of each of the four studies follows.

Employment Follow-Up

To assess DVR's impact in rehabilitating the disabled, JLARC undertook a comprehensive follow-up study of clients closed in FY 1974 and FY 1975. The aim of the study was to ascertain how many clients remain employed and at what level of income. The study covered three key areas. One area represented the general client population served by DVR--both those closed successfully and those closed unsuccessfully. This part of the study was intended to answer the overall question of how well DVR rehabilitates the clients it serves.

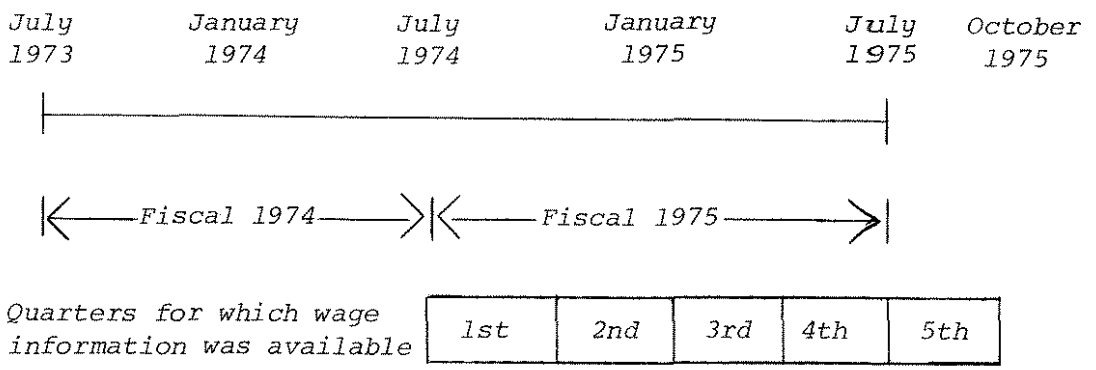
The second area consisted only of those considered severely disabled. This group was evaluated in relation to the general population who are generally less disabled and are more likely to be employed. In addition, the severely disabled were studied separately to see how well DVR might be expected to do under the new federal mandate to serve this group on a priority basis.

The third group consisted of those rehabilitated through a special unit. This group was studied because of the key role these units have played in DVR's past and because many of these units have either already been phased out or are currently under review by the agency.

By focusing on employment as a criterion for evaluating the agency's effectiveness, the study, by necessity, was restricted to only those closed in competitive, wage-paying jobs. This still covered the majority of DVR's rehabilitants since in FY 1975, all but 13% of DVR's successful rehabilitants were closed in competitive, wage-paying positions.

Employment data on individual clients was obtained by JLARC from a wage-record file maintained by the Virginia Employment Commission (VEC). The file covers all those who pay Unemployment Compensation Insurance in the State. This covers roughly 80% of all individuals employed in Virginia. Excluded are such major groups as farm laborers, the self-employed, some construction workers, public school employees, and city employees, to name a few. The file contained earnings information on a quarterly basis for the most recent five quarters. The period covered for this study included the third quarter of 1974 through the third quarter of 1975, as shown on following page.

Employment data from the wage file was obtained on randomly-selected samples of clients picked to represent the different areas under study. Except for the clients selected for the special units, all were selected randomly by computer from a master tape provided JLARC by the Department of all closures for FY 1974 and FY 1975. In the case of the special unit samples, clients had to be randomly picked by hand.



Each client sampled was then matched with the corresponding wage information from the VEC wage file. The match was made using social security numbers for each individual sampled. Always information was taken *from* the wage file. Never was any information added *to* the file. Afterwards, this wage information was paired with background data on each individual taken from the DVR Federal Quarterly Closure tape. The following specifies in more detail each sample drawn.

The General Sample. A stratified random sample of rehabilitants closed in competitive, wage-paying jobs was drawn for FY 1975. A separate, comparable sample was drawn for comparative purposes for those closed a year earlier in FY 1974. Both samples were stratified according to six broad families of disabilities to ensure enough clients of each type would be adequately represented. Stratifying the sample required that each subgroup or strata be weighted according to what its original proportion was to the total. As a result, all findings had to be weighted back to the original distribution in order for the results to accurately reflect the total. The following illustrates the procedure used.

Example: Almost as many clients with a hearing disability were sampled as with a visual disability (19 versus 25). Yet, almost three times as many individuals with a hearing problem were closed in competitive employment in FY 1975 as were closed with a visual problem. To make the two comparable, those with a hearing disability had to be weighted more than those with a visual problem. Table A-1 illustrates how the weights were employed.

Table A-1

EXPLANATION OF WEIGHTS

Type of Disability	Number Sampled	Number Closed Competitively - FY 1975	Weight
Visual	19	78	4.1
Hearing	25	257	10.3
Total	44	335	

Example: If 11 of the 19 visual cases sampled and 3 of the 25 hearing cases sampled were found to be employed, the total employment rate for these two groups combined would be 76/335 or 22.6%.

visual	*11 x 4.1*	=	*45.1*
hearing	*3 x 10.3*	=	*30.9*
			76.0

This procedure was applied throughout the study wherever a stratified sample was used. The results of such weighting are statistically just as valid as the results would be from a simple random sample of comparable size (actually more so since sampling error is reduced by stratifying). Tables A-2 and A-3 show the actual number of clients sampled for each of the two years by type of disability. Also shown is the total number of clients closed in each category and the weight associated with each.

Table A-2

SAMPLE OF CLIENTS SUCCESSFULLY REHABILITATED
IN WAGE-PAYING JOBS
IN FY 1975

Type of Disability	Number Sampled	Total Closed Competitively	Weight
Visual/Hearing			
Visual	19	78	4.1
Hearing	25	257	10.3
Orthopedic/Amputee			
Orthopedic	25	849	34.0
Amputee	13	108	8.3
Other Physical Conditions	61	1,916	31.4
Psychotic/Psychoneurotic	55	762	13.9
Retardation			
Mild	18	706	39.2
Moderate	15	220	14.7
Severe	12	30	2.5
Other Mental Disorders			
Personality Disorder	23	1,741	75.7
Alcoholism	8	158	19.8
Drug Addiction	15	201	13.4
Total	289	7,026[a]	
Total of all successful closures		9,139	

[a]This is one less than reported by DVR and can be accounted for by the fact that one retarded case was not coded.

In addition to those closed successfully, special samples were drawn of those closed unsuccessfully. One sample represented those who had received some services, while another represented those who received no services. In each case, only eligible clients were considered (28's and 30's). Both samples were based on clients closed in FY 1975. Table A-4 shows the number of clients in each sample and the proportion each is of the total. In neither case was the sample stratified so no weights had to be used.

Table A-3

SAMPLE OF CLIENTS SUCCESSFULLY REHABILITATED
IN WAGE-PAYING JOBS
IN FY 1974

Type of Disability	Number Sampled	Total Closed Competitively	Weight
Visual/Hearing			
Visual	18	116	6.4
Hearing	20	339	17.0
Orthopedic/Amputee			
Orthopedic	27	1,253	46.4
Amputee	15	184	12.3
Other Physical Conditions	78	2,480	31.8
Psychotic/Psychoneurotic	37	1,105	29.9
Retardation			
Mild	19	1,252	65.9
Moderate	15	393	26.2
Severe	13	58	4.5
Other Mental Disorders			
Personality Disorder	20	3,755	187.8
Alcoholism	8	214	26.8
Drug Addiction	14	220	15.7
Total	284	11,369	
Total of all successful closures		13,647	

Table A-4

SAMPLES OF CLIENTS UNSUCCESSFULLY REHABILITATED
IN FY 1975

Closed Unsuccessful	Number Sampled	Total Closed	Proportion of Total
With service	250	4,745	5.3%
Without service	266	567	46.9%

The Severely Disabled Sample. Three general groups of severely disabled were sampled; the retarded, the mentally ill, and the physically handicapped. Clients closed as successfully rehabilitated in FY 1975 were sampled for each of the three groups. In addition, a group of physically disabled clients rehabilitated in FY 1974 was also sampled for comparison purposes (coding problems on DVR's master tape precluded drawing a similar sample from FY 1974 for the mentally ill). Unlike the general sample, these samples were not restricted to

clients closed in competitive, wage-paying jobs. This restriction was not made until later when employment was analyzed. Thus, the initial sample of the severely disabled was made up of all closures and not just those closed competitively. This was done to allow some groups of severely disabled that might only have a few wage earners to be fully sampled so a follow-up could be done on these nonwage earners if it later was desired. As it turned out, this did not have to be done. Tables A-5 and A-6 show the samples for these groups of clients. As before, the samples were stratified by types of disabilities thus necessitating weights to be applied.

Table A-5

SAMPLE OF SEVERELY DISABLED CLIENTS
SUCCESSFULLY REHABILITATED
IN FY 1975[a]

Type of Disability	Number Sampled	Total Closed	Weight
Physical[b]			
Visual	12	12	1.0
Hearing	24	132	5.5
Orthopedic	41	206	5.0
Amputee	9	9	1.0
Other	23	23	1.0
Retarded			
Mild[c]	64	828	12.9
Moderate	50	290	5.8
Severe	54	85	1.6
Mentally Ill[d]			
Psychotic	62	365	5.9
Psychoneurotic	33	143	4.3

[a]Not restricted to those closed in competitive employment.
[b]Only those with conditions considered automatically severely disabled under RSA guidelines.
[c]This group is not considered severely disabled but was sampled in order to be compared against the other two groups of retarded that are.
[d]Only those coded as severe on DVR's RSA 300 tape.

The Special Unit Sample. Separate samples were drawn to represent clients successfully rehabilitated through four different types of special units in FY 1975: Mental Health Units, Correctional Units, Welfare Units, and School Units. Since clients rehabilitated through any of these units can only be identified through the counselor caseload number assigned to each particular unit, the samples had to be drawn randomly by hand from DVR's monthly Master List instead of from DVR's Master RSA 300 tape. (Caseload numbers are not included on the DVR Master tape.) These samples were drawn using the last digit of the client's social security number. The following illustrates the procedure used:

If the sample needed was 10% of the total closed, then one number between one and ten would be randomly picked and all cases closed from that type of unit with a social security number ending in the number picked would enter the sample. If 20% was needed, then two numbers would be picked, etc.

Except for the correctional unit sample, all samples were simple random samples that did not require weighting. The sample for correctional units was stratified so that units serving primarily youthful offenders could be analyzed separately if desired. Since the samples were drawn from the monthly Master Lists, it was impossible to screen out only those closed in competitive, wage-paying jobs. (This information is not included on the Master Lists.) Therefore, as with the samples of the severely disabled, this restriction was not made until later when employment was analyzed. Table A-7 shows the samples drawn for each of the four different types of units.

VCVH. In addition to the follow-up study of DVR clients, a separate study was conducted of clients rehabilitated through the Virginia Commission for the Visually Handicapped (VCVH). Samples for this study were drawn by hand selecting every *nth* case from a list of closures provided JLARC by VCVH. In each instance, the number of cases skipped *(n)* was determined by the size of the sample required with the first case being selected by random.

Two samples were drawn--one for FY 1975 and one for FY 1974. Both represented successful closures for each particular year. These samples were not restricted to those closed in competitive, wage-paying jobs. This restriction

Table A-6

SAMPLE OF SEVERELY PHYSICALLY DISABLED CLIENTS SUCCESSFULLY REHABILITATED IN FY 1974[a]

Type of Disability[b]	Number Sampled	Total Closed	Weight
Visual[c]			
Cataract or Congenital Malformation	4	10	2.5
All Other	6	6	1.0
Hearing	23	76	3.3
Orthopedics	26	248	9.5
Amputee	8	8	1.0
Other	24	42	1.7

[a]Not restricted to those closed in competitive employment.
[b]Only those with conditions considered automatically severely disabled under RSA guidelines.
[c]Particular visual disabilities were controlled for to make the group comparable to those closed in this category in FY 1975.

Table A-7

SAMPLE OF CLIENTS SUCCESSFULLY REHABILITATED
THROUGH SPECIAL UNITS
IN FY 1975

Type of Units	Number Sampled	Total Closed	Weight
Corrections	104	482	
Youth Units[a]	51	288	5.6
Chesapeake Jail	14	14	1.0
Federal Reformatory	39	180	4.6
School	128	924	1.0
Mental Health	91	591	1.0
Welfare	72	791	1.0
Total	395	2,788	

[a]This included units at Beaumont School for Boys, Bon Air School for Girls, Natural Bridge, and Southampton.

Table A-8

SAMPLE OF CLIENTS SUCCESSFULLY REHABILITATED
IN FY 1974 AND FY 1975 THROUGH VCVH

Year Closed	Total Closed	Number Sampled	Number Sampled Closed Competitively
1974	643	198	60
1975	623	229	60[a]

[a]Four of these cases had no Social Security number leaving 56 to represent this year.

was imposed later at the time employment was analyzed. Table A-8 shows the total number of clients successfully closed in each year, the number sampled, and the number sampled who were closed competitively. Neither sample was stratified, thus eliminating the need for weighting.

Limitations-DVR

The results of the employment follow-up were limited in two important respects. One, an unusually large number of clients sampled were not covered on the VEC wage file. Of those sampled who were closed successfully in FY 1975, 43% had no earnings reported in the quarter in which they were closed. An

examination of the case files reviewed by JLARC revealed that this could be explained for the most part by the fact that a larger number of DVR clients held jobs not covered on the wage file than was true for the State as a whole. The cases reviewed showed that roughly the same proportion, with no earnings reported in the quarter of closure, were found--45 out of 108 or 43%--as was found in the employment follow-up sample. Of these 45 cases, 29 held jobs for which no Unemployment Compensation is required. Others were either miscoded, employed but not at time of closure, or otherwise could not be determined. Table A-9 provides a complete breakdown of all 108 cases.

Table A-9

EMPLOYMENT STATUS AT CLOSURE OF CLIENTS USED IN CASE FILE REVIEW

	Employment Status at Close[a]	
	Number	Percent[b]
Earnings Reported	62	57
At place indicated	42	39
Elsewhere	10	9
Don't know	10	9
No Earnings Reported	45	42
Job not covered	29	28
Working in government	6	6
Working in military	6	6
Public school	3	3
Out-of-State	3	3
Laborer/maid, etc.	11	10
Employed sometime at place indicated but not at closure	8	7
Miscoded, not competitive	2	2
Don't know	6	6
Not Available	1	1
Total	108	100%

[a]Due to weighting these figures are not directly applicable to DVR's client population as a whole.
[b]Figures may not add due to rounding.

Since such a large number of DVR's clients did not appear on the wage file, this restricts the results to only those for which earnings were reported. Left in doubt is the question of whether those with no earnings reported remain employed any longer or shorter than those whose employment was known. As a result, most of the findings shown are based on only those with reported earnings. Table A-10 shows the proportion of those in each sample which had no reported earnings at close.

Table A-10

WAGEFILE COVERAGE
FOR FY 1975 SAMPLES[a]

Sample	Total Number in Sample	Number With Reported Earnings at Closure	Percent With Reported Earnings at Closure
General Population	289	168	57%*
Physical			
Traditional	82	43	50%*
Medical	61	35	57%
Mental			
Behavior Disorders, Drug Addicts, Alcoholics	46	30	59%*
Psychotics, Psychoneurotics	55	37	67%*
Retarded	45	23	61%*
Severes			
Physical Severes	80	37	50%*
Physical Nonseveres	116	66	56%*
Retarded			
Mild	57	38	67%*
Moderate, Severe	56	25	46%*
Severe Psychotics, Psychoneurotics	70	38	55%*
Nonsevere Psychotics, Psychoneurotics	27	19	70%
Special Units			
Corrections	100	46	48%*
School	107	72	65%
Mental Health	62	29	47%
Welfare	61	35	57%

[a]Coverage for FY 1974 samples could not be determined since earnings on clients closed in that year were not available for the quarter of closure.

*Percent based on weighted sample.

A second factor which limits the results of the follow-up is due to the fact that findings are based on samples and as such are subject to normally accepted statistical limitations associated with using sample data. Most of the various figures which are based on the results of the follow-up show ranges to reflect the amount of variation expected due to sampling error. The following formula was used to calculate the confidence interval for these figures. A 95% confidence level was used such that statistically, were the study to be repeated, 95 times out of 100 the new value would lie within the range indicated.

$$\text{Standard error} \times 1.96 = \sqrt{\frac{(P)\ (100-P)}{N}}$$

P = Percentage observed
N = Size of sample

Case File Review

As part of its evaluation, JLARC reviewed the files of 172 cased closed in FY 1975. The majority of these cases were successful closures, though some unsuccessful closures were sampled as well. In reviewing those cases, JLARC examined the overall role of the counselor in rehabilitating the client. In particular, such factors were examined as the eligibility of the client, the coherence of the rehabilitation plan, the appropriateness of the services being provided, and the extent to which the counselor may have helped place the client in a job.

To help interpret the results of the employment follow-up, the majority of the successful closures were taken from the general sample of 289 clients used for the VEC match. This enabled JLARC to link the results of the follow-up to what was found in the case file review. A total of 108 cases were randomly picked from the 289 cases drawn previously for the other sample. These 108 cases, however, only represented those closed in competitive employment. Thirteen additional cases were randomly picked and added to these to represent other noncompetitive successful closures. Table A-11 shows the distribution of the cases closed competitively and noncompetitively by type of disability. Also shown in the table is the number of different types of unsuccessful cases included as part of the review.

To review the cases, JLARC had DVR send these files from the various field offices. The files were then turned over to JLARC for a limited time period. During this period, JLARC reviewed each file recording key data on a standard form (copy of form shown on page A-16). The files were kept under lock at all times and were only accessible to members of the study team. Afterward, the files were returned to DVR.

Limitations. The 172 cases selected for the case file review were picked to represent a cross-section of clients seen by the agency. However, due to the selection process, some categories of disabilities, like drug addiction, were overrepresented while others were underrepresented. This limits the results of this review to general conclusions instead of more precise statistical analysis of any one disability group.

Table A-11

SAMPLE OF CLIENTS CLOSED IN FY 1975 FOR USE IN CASEFILE REVIEW

Successful Closures	Number Sampled	Total Closed Competitively[a]	Total Closed Noncompetitively	Total Closed
Type of Disability:				
Visual/Hearing				
Visual	19	8	-	8
Hearing	25	6	-	6
Orthopedic/Amputee				
Orthopedic	25	11	3	14
Amputee	13	4	-	4
Other Physical Conditions	61	25	5	30
Psychotic/Psychoneurotic	55	23	2	25
Retardation				
Mild	18	4	1	5
Moderate	15	5	-	5
Severe	12	5	2	7
Other Mental Disorders				
Personality Disorder	23	6	-	6
Alcoholism	8	5	-	5
Drug Addiction	15	6	-	6
Total	289	108	13	121

Unsuccessful Closures		
Accepted	35	
Received Services (28's)		28
Received No Services (30's)		7
Not Accepted (08's)	16	
Total	51	
TOTAL CASES REVIEWED	172	

[a]Sampled from 289 cases included in general sample for VEC follow-up shown in Table A-2.

Phone Follow-Up

To serve as a kind of spot-check on the information contained in the case files and to make sure clients were receiving the services indicated, JLARC called some of the clients sampled for the case file review. Only clients closed successfully were called. A total of 29 clients were reached out of the 121 possible. Calls were not attempted, however, on all 121 cases. Attempts were only made on slightly over a third of the cases. Many of those whom JLARC did not try to reach had no phone number given or had an unlisted number. Others had moved or had disabilities which discouraged communication. A standard set of questions was used in making the calls. The results, however, were based on too few cases to be used except as a supplement to other available data.

Counselor and Supervisor Interviews

As part of its review process, JLARC interviewed a total of 98 counselors and 28 supervisors across the State. The number interviewed in each of DVR's four separate regions is shown on Table A-12. Together, the counselors and supervisors represent a good cross section of DVR's field personnel. JLARC made a point of interviewing counselors of different types. Counselors were singled out who were particularly high or low on a number of key characteristics: workload, case expenditures, total rehabilitations, percent of Woodrow Wilson cases, percent of cases requiring restorations, percent of cases rehabilitated, percent of cases accepted. In addition, offices with counselors who were considered more average were visited as well for comparative purposes. Lastly, JLARC visited all but a few of DVR's special units because of their significance to the study.

Table A-12

GEOGRAPHIC DISTRIBUTION OF COUNSELORS AND SUPERVISORS INTERVIEWED BY JLARC

	Region				
	I	II	III	IV	Total
Counselors	27	17	13	41	98
Supervisors	6	6	5	11	28

FORM USED IN CASE FILE REVIEW

Name (4e) _____ Caseload #(4e) _____ Counselor (4e) _____

SSN (4e) _____ Referral Source (4) _____

Age (4) _____ Referral Date (4) _____

Closure Date (4e) _____ Work Status (4e) _____

PA at Closure (4e) _____

E. SERVICE PROVIDED OR ARRANGED FOR BY AGENCY

With Cost (1)	Without Cost (2)			
		10		Diagnostic and Evaluation
		11		Restoration (Physical or Mental)
		12	TRAINING	College or University
		13		Other academic (ELEM or HS)
		14		Business School or College
		15		Vocational School
		16		On-the-job
		17		Personal & Voc. Adjustment
		18		Miscellaneous
		19		Maintenance
		20		Other services
		21		Service to other family members
		22		Transportation

Months in 18(4e) _____

20-22(4e) _____

Weekly Earnings at Referral _____

Occupation (4e) _____ Code (4e) _____

Employer (4e) _____

_____

Phone (4) _____ Public Assistance at Closure _____

Highest Grade (4) _____ Family Income (month) (4) _____

Primary Source of spt (ref)(4) _____ Fed ID (4e) _____

Weekly Earnings at Referral (4) _____ Work Status at Referral (4) _____

Primary Disability (5) _____ Code (5) _____

Secondary Disability (5) _____ Code (5) _____

Vocational Objective (5) _____ Code (5) _____

Services to be Provided and Financial Responsibility (5) _____

_____

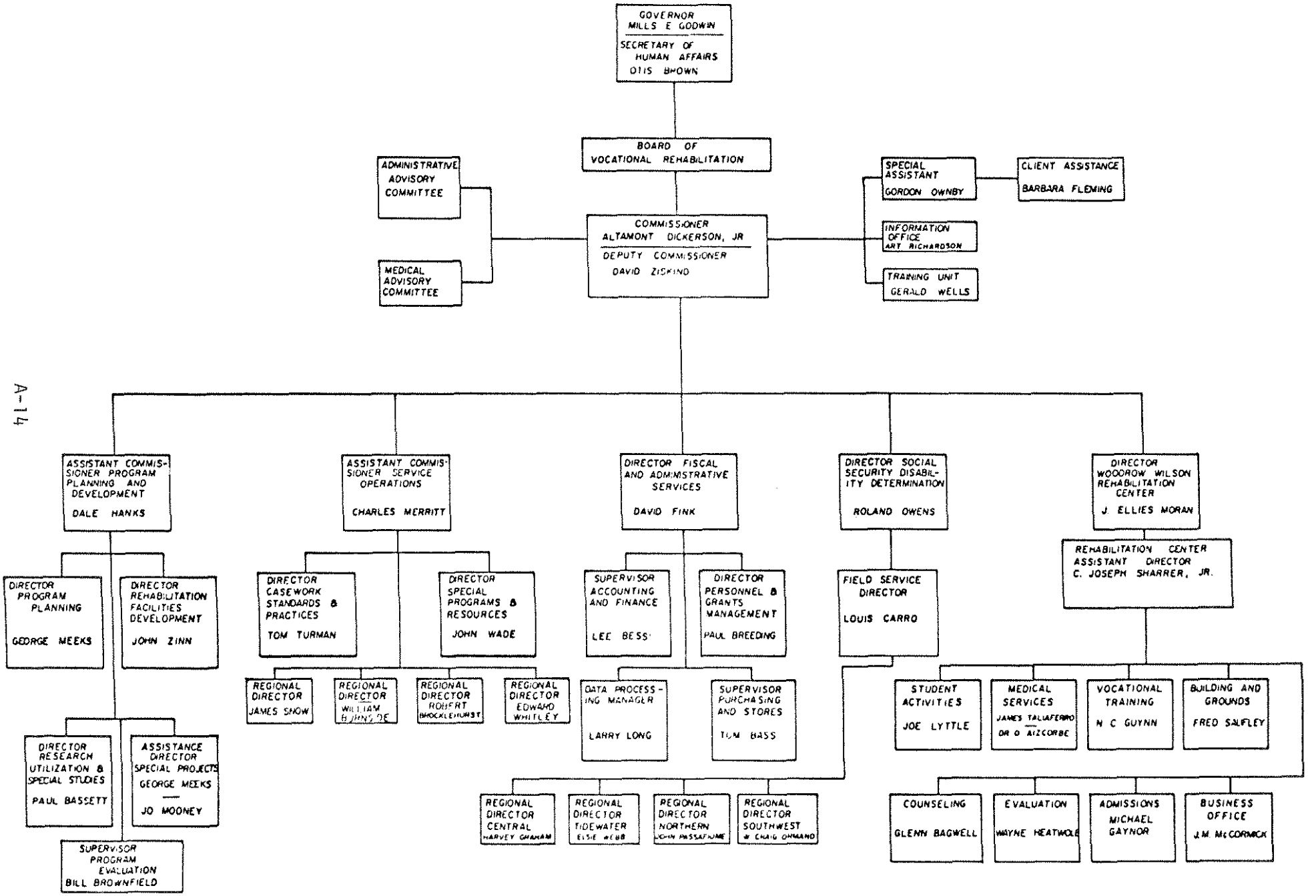
Cost (17) _____

Diagnostic Information: _____

Narrative: _____

Appendix 1

Department of Vocational Rehabilitation Organization Chart



Appendix 2

FIELD AND SPECIAL UNIT PROGRAM GROWTH
1964-73

Before 1964	1964-66	1966-68	1968-70	1970-72	1972-73
Field-14 offices		Marion St. Paul Danville Farmville	Portsmouth Harrisonburg Warsaw Franklin Hampton Radford Martinsville Woodbridge Va. Beach		Richlands Salem
School	Alexandria Fairfax County Richmond	Harrisonburg Rockingham County Charlottes-ville Roanoke County Albemarle County	Chesterfield County Richmond Juvenile Delinquency Program		
Corrections	Beaumont Bon Air Natural Bridge Petersburg Federal Reformatory Richmond Study Home*		Southampton Correctional Farm		
Welfare			Richmond Va. Beach Norfolk Model City	Danville-Pittsylvania Colonial Heights-Chesterfield Portsmouth Roanoke Chesapeake Smyth-Wythe Counties	Halifax/South Boston
Hospital		Central State Western State	Eastern State Lynchburg School and Hospital Southwestern State	Catawba Geriatric	
Drug					Roanoke Annandale Richmond Norfolk Portsmouth
Other				Spinal Cord Project	

*Dropped by 6/68

Source: DVR Annual Reports 1966-73.

Appendix 3

NEEDS ANALYSIS

Federal regulations require that DVR study the needs of handicapped individuals with attention given to the relative need for VR services of different segments of the handicapped population. Particular emphasis is placed on measuring the service need of the severely disabled.

JLARC found that although several studies have been done in this area, reliable data on the incidence of handicapping conditions are not easily obtained. Differences in the definition of a handicap, survey techniques, data collection, and ages included all contribute to the problem of data reliability. Furthermore, most studies have been national in scope and are not capable of providing detailed findings which can be used specifically for Virginia.

Estimate of Disability

The best estimate of the incidence of overall disability are crude and can only be used as a benchmark. DVR relies primarily on data provided by a 1968 report of the Governor's Study Commission which has been updated with recent population estimates. JLARC reviewed other data sources and concluded that, in general, the estimates developed by DVR are reasonable and probably reflect the best information currently available.

Governor's Study Commission. This survey was part of a national effort sponsored by the Rehabilitation Services Administration (RSA). In 1967, the RSA funded individual state projects to develop plans that would assist states in improving services. By November, 1969, RSA had received surveys from 43 states including each state's estimate of the number of handicapped. While RSA found that most states had difficulty in estimating the number of handicapped and did not provide adequate documentation on how the estimates were obtained, they estimated that 3.4% of the general population is handicapped and could benefit from VR services.

In Virginia, the Commission selected five governmental jurisdictions (Augusta County, Wise County, Petersburg, Norfolk, and Alexandria) based on various demographic characteristics. From each community, a representative sample of families and adults was chosen. Each person residing in the household was included in the reporting, but only family members and relatives were analyzed. Information on 4,261 persons was recorded.

Of the 4,261 persons interviewed, 1,328 reported some limitation. Those who thought themselves limited to some extent accounted for 20.6% (274), while 12.2% (163) were limited with respect to their ability to work. Of this group, it was estimated that 4.5% were eligible for VR services (age not considered).

Based on this survey, DVR developed the following estimates of prevalence and eligibility for 1975.

DVR TARGET POPULATIONS, 1975
Noninstitutional

	Total	Eligible
Orthopedic	101,300	29,300
Hearing	17,000	4,500
Respiratory	33,100	5,300
Mental Retardation	137,900	28,500
Mental Illness	64,700	7,000
Epilepsy	37,700	3,000
Cardiac	85,600	6,700
Total	477,300	84,300

Source: "Report on the Workshop on Client Identification" DVR, April, 1974, Appendix C.

For planning purposes, DVR has updated these estimates for July 1, 1977, based upon revised population estimates for Virginia. In "Annex B, Scope of the VR Problem in Terms of Client Populations", DVR presents regional breakdowns by disability for cities and counties. These estimates are based upon the Governor's Commission Survey and, if accumulated, give a total of 531,275 disabled, of which 105,998 are estimated to be eligible for VR services.

Urban Institute Report. The Urban Institute recently reviewed most of the major national studies for RSA in an effort to identify the best estimates. They concluded that a 1966 Social Security Administration study was the most accurate. The Urban Institute used this data to estimate that there were 706,000 disabled persons of all ages in Virginia. However, since DVR is primarily interested in the work-age population (18-64), this figure is too high. Therefore, DVR used the RSA total of disabled persons (23.3 million) and multiplied it by the percentage of the nation's population in Virginia. The result was 534,000 disabled persons, which compares favorable with the estimates based on the Governor's Study Commission report (531,000). An additional 12,000 should be added to this total to reflect the number of institutionalized persons who may be eligible. Therefore, there are at least 500,000 disabled Virginians based on the best estimates presently available.

Estimates of the Need for Vocational Rehabilitation

Most persons who are disabled are not vocationally handicapped and in need of DVR services. Many disabled persons have overcome their own handicaps, while others have been assisted by other agencies and organizations such as the Veteran's Administration. Data on the number of disabled *eligible* persons is very poorly developed. DVR uses estimates based on the findings of the 1968 Governor's Study and on a 1965 National Rehabilitation Association study.

Highlights of National Studies

DVR estimates that there are 106,000 disabled eligible persons in Virginia. This estimate is based on old data and is not supported by national

findings since national studies have not dealt with the issue of eligibility to any great degree. Despite this, JLARC recognizes that there are no better data available. Therefore, an estimate that 100,000 disabled eligible persons are currently in Virginia is accepted as the best available.

PREVALENCE OF SELECTED DISABILITIES

Orthopedic Impairment. The American Academy of Orthopedic Surgeons estimate that approximately 13.2 million persons have a "significant orthopedic impairment". The incidence among the over 65 is five times greater than under age 25, and about 400,000 persons have major amputations.

Mental Retardation. It is estimated that approximately six million people (3% of the population) are mentally retarded (most are only mildly retarded and may already be employed). Approximately 690,000 retarded people nationwide are, however, of working age and idle, of which 400,000 could be gainfully employed with VR services. Nearly all of these would be moderately retarded (IQ below 50 with maladaptive behavior). The National Children's Rehabilitation Center has estimated that 12.5 persons per 1,000 population are mentally retarded in Virginia, or approximately 57,700 persons.

Communicative Disorders. RSA's Office of Deafness and Communicative Disorders estimates that 1.8 million persons in the U. S. are deaf, of which approximately 500,000 need VR services. An additional 10 million persons have a significant hearing impairment, of which 2 million are potentially eligible for VR services. An estimated 2 million persons have a speech impairment of which 500,000 would be eligible for VR services.

Blind and Visually Handicapped. RSA's Office of the Blind and Visually Handicapped estimates that 475,200 persons are blind of which 38,800 are VR eligible, while an additional 712,800 persons have a severe visual handicap, of which 96,900 need VR services.

Mental Illness. An estimated 500,000 persons nationally are in psychiatric institutions, while several million other persons with serious mental and emotional disorders reside in the community and need VR services. Another estimate is that one out of every seven individuals seeks professional help for problems which can precipitate psychiatric disorders.

Hemophilia. This occurs in approximately one of every 4,000-10,000 persons (nearly always males).

Sickle Cell Anemia. Nationally, about one of every 1,000 blacks have this disease and one of every 500 is born with it. In 1975, there were 300 active cases registered at MCV.

Cardiovascular. It is estimated that 25% of all persons with severe disabilities have cardiovascular impairments, while in Virginia it is estimated that 607,000 persons have cardiovascular diseases.

Epilepsy. The Urban Institute estimates that approximately 4 million individuals suffer from epilepsy. Another much smaller estimate is one percent

of the population or about 210,000 persons, of which 50% are chronic cases. The National Children's Rehabilitation Center estimates there are 2.8 epileptics per 1,000 population in Virginia, or about 13,000 cases.

Multiple Sclerosis. Multiple Sclerosis is a severe disability and according to the Urban Institute affects 500,000 persons. Another estimate is that less than 80 per 100,000 persons, or about 169,000 persons (based on 1974 U. S. population estimates) suffer from MS. The average case can be profitably rehabilitated for employment or homemaking.

Cerebral Palsy. The United Cerebral Palsy Association estimates 750,000 individuals have cerebral palsy. Estimates of those who are of working age and could benefit from VR services are not available. The National Children's Rehabilitation Center estimates that 1 out of every 1,000 persons in Virginia have cerebral palsy (approximately 5,000).

Muscular Dystrophy. Muscular Dystrophy is a severe disability and the Muscular Dystrophy Association estimates 200,000 persons nationally suffer from this condition. Very few persons with this condition, however, are expected to be employable with VR services. It is estimated that there are 4,550 such persons in Virginia.

Cystic Fibrosis. This is a severe disability and affects about 40,000 persons. Because of limited longevity, employment potential is also limited.

Cancer. The American Cancer Society estimates 1 million people are being treated for cancer at any given moment. Information of the number who could benefit from VR services, however, does not exist.

Renal Disease. Currently, an estimated 15,000 persons are undergoing renal dialysis, and an additional 30,000-60,000 persons need this treatment. It is estimated that there are approximately 250 new cases each year in Virginia.

Respiratory Conditions. According to the National Center for Health Statistics, nearly 14 million people suffer from bronchitis, asthma, or emphysema, of which 4 to 5 million are severely handicapped.

Quadripelegia, Paraplegia, and Other Spinal Cord Conditions. It is estimated that more than 125,000 individuals are paralyzed by a spinal cord injury.

Appendix 4

QUARTERS OF CONTINUOUS EMPLOYMENT
SUCCESSFUL CLOSURES FOR FY 75

	Quarter Closed	Quarters Since Closure 1	2	3	4	All Possible Quarters Combined
	%	%	%	%	%	%
No Reported Earnings:	43	55	66	66	72	66
At Close	(43)	(43)	(42)	(37)	(35)	(43)
After Close	--	(12)	(24)	(29)	(37)	(23)
Continuous Earnings Report:	57	45	34	34	28	34
Total	100	100	100	100	100	100
Base:	(289)	(289)	(213)	(128)	(50)	(289)

Source: JLARC Employment Follow-Up Study.

Appendix 5

QUARTERS OF CONTINUOUS EMPLOYMENT
SUCCESSFUL CLOSURES FOR FY 74

	Quarters Since Closure 1	2	3	4	5	6	7	8
	%	%	%	%	%	%	%	%
No Reported Earnings:	59	62	67	65	71	74	75	64
At Close	----------not available*----------							
After Close	(--)	(4)	(7)	(10)	(16)	(19)	(21)	(21)
Continuous Earnings Reported:	41	38	33	35	29	26	25	36
Total	100	100	100	100	100	100	100	100
Base:	(76)	(134)	(204)	(284)	(284)	(208)	(150)	(80)

*Clients closed in Fiscal 1974 were closed prior to the period for which there was wage information.

Source: JLARC Employment Follow-Up Study.

Appendix 6

FISCAL 1975
DEPARTMENT OF VOCATIONAL REHABILITATION EXPENDITURES
FOR SPECIALZED FACILITIES AND PROGRAMS

Special Programs	
Correctional Institutions	$ 573,860
Mental Institutions	1,480,840
Drug Rehabilitation	401,540
Public and Private Facilities and Programs	
Schools	1,253,275
Private Agencies	313,360
Total	$4,022,875

Source: Virginia Department of Vocational Rehabilitation, "1974-75 DVR Annual Report."

Appendix 7

VOCATIONAL REHABILITATION
STATE CORRECTIONS PROGRAMS EXPENDITURES

Natural Bridge	$ 56,841.04
Bon Air	113,584.39
Beaumont	216,461.17
Prerelease Center (Beaumont)	16,955.77
Southampton	170,027.60
Total	$573,869.97

Source: Virginia Department of Vocational Rehabilitation, "Expenditure Report by Region, June, 1975."

Appendix 8

FISCAL 1975
VOCATINAL REHABILITATION DRUG PROGRAM EXPENDITURES

Roanoke Drug Program	$ 72,870.97
RADAC - Richmond	308.89
Annandale Drug Program	58,055.91
Alexandria Drug Program	29,851.74
Western State Drug Program	8,331.80
Richmond Drug Program	84,504.81
Norfolk Drug Program	69,685.29
Hampton Drug Program	11,755.68
Portsmouth Drug Program	66,715.83
Adjustment	- 541.00
Total	$401,540.00

Source: Virginia Department of Vocational Rehabilitation, "Expenditure Report by Region, June, 1975."

Appendix 9

FISCAL 1975
VOCATIONAL REHABILITATION
EXPENDITURES FOR UNITS AT MENTAL INSTITUTIONS

Lynchburg Training School	$ 190,330.70
Southwestern State Hospital	191,942.22
Western State Hospital	323,594.61
Central State Hospital	359,635.62
Eastern State Hospital	415,347.54
Total	$1,480,850.69

Source: Virginia Department of Vocational Rehabilitation, "Expenditure Report by Region, June, 1975."

Appendix 10

FISCAL 1975
VOCATIONAL REHABILITATION
EXPENDITURES FOR SCHOOL UNITS

Fairfax School Unit	$ 203,403.08
Alexandria School Unit	141,986.95
Rockingham School Unit	7,608.86
Harrisonburg School Unit	154,819.74
Albemarle School Unit	57,045.82
Richmond School Unit	379,000.22
Chesterfield School Unit	136,514.16
Charlottesville School Unit	45,720.08
Roanoke School Unit	127,178.33
Total	$1,253,277.00

Source: Virginia Department of Vocational Rehabilitation, "Expenditure Report by Region, 1975."

Appendix 11

FISCAL 1975
VOCATIONAL REHABILITATION
EXPENDITURES FOR ESTABLISHMENT OF VOCATIONAL REHABILITATION FACILITIES

Danville Goodwill	$14,834.78	Tinker Mountain Workshop (Troutville)	$ 4,074.12
Richmond Goodwill	7,107.72	Lewis B. Puller Vocational Center (Saluda)	11,794.25
Valley Workshop (Buean Vista, Covington, Staunton, Waynesboro)	18,687,32	Goodwill Industries of Tenneva (Gate City)	12,424.18
MARC Workshop (Martinsville)	1,463.92	Faith Workshops (Williamsburg)	23,161.43
Cordet Foundation (Richmond)	3,474.92	Eastern Shore Vocational Center (Exmore)	7,650.15
Northwestern Workshop (Winchester)	113.61	Southside Sheltered Workshop (Petersburg)	7,518.80
Tri-County Workshop	93,633.08	PARC Workshop (Stuart)	4,490.23
New River Valley Workshop	13,076.50	Sheltered Homes of Alexandria (Springfield)	4,223.24
Friendship Industries (Harrisonburg)	17,259.57	Halfway Housing, Inc. (Staunton)	2,923.29
Goodwill of Greater Virginia (Roanoke)	6,073.76	Mt. Rogers Sheltered Workshop (Marion)	16,497.13
Lynchburg Works	624.00	Shenandoah County Sheltered Workshop (New Market)	1,461.29
Tri-City Self-Help (Petersburg)	6,009.68	Lynchburg Workshop	5,877.25
Sheltered Occupation Center of Northern Virginia	22,414.85	Bristol Shelter	2,988.41
Workshop Five (Charlottesville)	3,501.04	Total	$313,358.00

Source: Virginia Department of Vocational Rehabilitation, "Expenditure Report by Region, June, 1975."

Appendix 12

DEPARTMENT OF VOCATIONAL REHABILITATION
SPECIAL FEDERAL GRANTS
FISCAL YEAR 1975

Project or Grant	Total Expenditures	Source of Funds
Catawba Rehabilitation Workshop	$ 64,169.67	90% Federal 10% State
Danville Welfare	210,582.62	80% Federal 20% State
Southwestern Virginia Cooperative Welfare Project	245,094.07	80% Federal 20% State
Roanoke Welfare	262,340.54	80% Federal 20% State
Arlington Welfare	21,124.47	80% Federal 20% State
Waynesboro Valley Workshop	76,135.93	80% Federal 20% State
Richmond Welfare	201,408.97	80% Federal 20% State
Halifax/South Boston Welfare	67,476.64	80% Federal 20% State
Chesterfield/Colonial Heights Welfare	87,238.23	80% Federal 20% State
Chesapeake Welfare	48,432.60	80% Federal 20% State
Portsmouth Welfare	269,353.43	80% Federal 20% State
Norfolk Welfare	265,143.67	80% Federal 20% State
Model Cities Health Welfare	42,393.00	80% Federal 20% State
Chesapeake Jail	34,817.68	80% Federal 20% State
WWRC Student Activities	188,306.11	80% Federal 20% State
WWRC Deaf Project	62,042.11	80% Federal 20% State
WWRC - Training Services	305,347.28	90% Federal 10% State
Spinal Cord Injury Grant	227,422.37	90% Federal 10% State
Spinal Cord Injury Project	169,758.50	80% Federal 20% State
Homebound Computer Project	29,091.18	90% Federal 10% State
Research Special Grant	31,645.10	80% Federal 20% State
In-Service Training	155,610.53	90% Federal 10% State
Client Assistant Project	40,852.40	100% Federal
Community Orientation	39,448.76	90% Federal 10% State
Manpower Development and Training Project	55,265.71	90% Federal 10% State
Industrial Learning	48,000.00	80% Federal 20% State
Health Department Va. Medical Assistance	36,580.12	100% Va. Dept. of Health
Aid to Permanently and Totally Disabled and Blind	991.18	100% Va. Dept. of Welfare
SSDI - Trust Fund	1,462,500.50	100% Federal
SSI - Vocational Rehabilitation Program	722,947.71	100% Federal
Adjustment	1,174.00	
Total	$5,480,696.00	

Source: Virginia Department of Vocational Rehabilitation, "Expenditure Report by Region," June, 1975.

Appendix 13

DEPARTMENT OF VOCATIONAL REHABILITATION EXPENDITURES
AND REVENUES FOR FY 1967 TO FY 1976

EXPENDITURES	1967	1968	1969	1970	1971	1972	1973	1974	1975	1976 Estimated
Administration	$ 306,211	$ 359,420	$ 440,172	$ 550,239	$ 690,050	$ 691,369	$ 734,629	$ 819,535	$ 895,435	$ 1,193,796
Counseling and Placement	2,152,895	2,094,737	2,961,069	4,035,512	4,478,655	4,540,030	4,985,403	3,327,470	4,141,340	5,519,098
Service to Individuals	3,454,394	5,887,606	7,182,070	9,578,469	10,149,079	12,034,037	12,461,654	7,832,590[2]	8,779,710	8,032,549[4]
Specialized Facilities and Programs[1]	342,559	389,257	807,942	690,131	314,776	1,008,440	660,322	3,376,195	4,022,875	5,843,387
Special Federal Grants	119,472	381,670	691,559	1,017,632	911,102	1,164,224	1,678,705	3,466,520	5,470,350	3,116,448
Disability Determination	674,696	845,250	1,010,785	946,552	1,374,960	1,673,325	2,063,534	3,128,209	3,744,346	5,030,575
TOTAL EXPENDITURES	$7,050,227	$9,957,940	$13,093,597	$16,818,535	$17,918,622	$21,111,445	$22,584,247	$21,950,519	$27,054,056	$28,735,853
SOURCES OF REVENUE										
State General Fund	$1,149,565	$1,392,550	$ 1,816,240	$ 2,053,955	$ 2,435,769	$ 2,640,999	$ 2,891,883	$ 2,891,905[3]	$ 3,816,615[3]	$ 3,801,667
Other State Funds	458,085	593,402	656,241	1,404,966	791,796	1,187,437	969,154	25,000	25,000	-
Other Public and Private Funds	224,967	300,027	349,971	87,698	131,360	103,831	236,785	198,350	306,560	124,100
Federal Funds	5,217,610	7,671,961	10,271,145	13,271,916	14,559,697	17,179,178	18,486,425	18,835,264	22,905,881	24,822,397
TOTAL REVENUES	$7,050,227	$9,957,940	$13,093,597	$16,818,535	$17,918,622	$21,111,445	$22,584,247	$21,950,519	$27,054,056	$28,748,164

1. Includes small businesses, construction, establishment of rehabilitation facilities, facilities and services to groups, minor medical, recruitment and training expenditures.
2. Includes $409,670 capital outlay to WWRC (within 10% of section 110 restriction)
3. All State funds except for $25,000 from Department of Education
4. Anticipates $2 million of special fund revenues to be added.

Sources: 1968-1975 DVR Annual Reports, and 1976 DVR Board Financial Report.

Appendix 14

DEPARTMENT OF VOCATIONAL REHABILITATION
ANALYSIS OF EXPENDITURES BY APPROPRIATION FOR FIRST HALF FISCAL 1976

	Personal Service	Contractual Service	Supplies & Materials	Grants & Shared Revenues	Equipment Replacement	Equipment Additional	Current Charges & Obligations	Pensions and Retirement	Case Services	Total
Administration	378,802.25	77,632.76	12,297.20	1,795.58		399.82	51,954.48	54,355.20		631,910.95[1]
Disability Determination	961,046.17	857,805.50	20,733.55	1,283.60		17,450.00	211,472.30	203,621.50		2,273,412.62
Drug Rehabilitation	53,054.85	1,316.34						12,442.40	118,072.33	183,885.92
General Rehabilitation Service (Field Program)	1,367,482.83	468,074.27	34,732.40		3,849.82	37,898.61	185,635.59	250,149.60	3,315,000.09	5,662,823.21
Correctional Institutions	212,738.02	15,088.43	2,253.94		489.50	357.52	2,278.69	38,593.40	21,419.37	293,218.87
Public & Private Agencies	266,919.22	303,570.79	1,013.86		739.00	3,554.69	4,671.42	48,316.00	204,848.97	833,633.95
Mental Institutions	456,030.93	25,558.70	10,230.85		7,869.17	6,176.28	3,419.31	89,088.00	152,063.43	750,436.67
Special Projects	951,232.04	794,811.23	5,340.90	1,629.50	2,998.21	13,192.41	53,104.97	174,152.88	1,291.430.10	3,287,892.24
Total	4,647,306.31	2,543,858.02	86,602.70	4,708.68	15,945.70	79,029.33	512,536.76	870,718.98	5,102,834.29	13,918,214.43

[1]This appropriation was credited with $54,674 due to recoveries of equipment and tools.

Source: Department of Vocational Rehabilitation, *Expenditure Report by Division*, VR-97, December 1975.

APPENDIX - AGENCY RESPONSES

ALTAMONT DICKERSON, JI
COMMISSIONER

COMMONWEALTH of VIRGINIA

DEPARTMENT OF VOCATIONAL REHABILITATION

COMMONWEALTH BUILDING
P. O. Box 11045

4615 WEST BROAD STREET
RICHMOND, VIRGINIA 23230

Telephone: (804) 786-2091

November 1, 1976

NOV 3 1976

Mr. Ray D. Pethtel, Director
Joint Legislative Audit and Review
Commission
Room 200
823 E. Main Street
Richmond, Virginia 23219

Dear Mr. Pethtel:

Attached you will find the comments of the Department of Vocational Rehabilitation on the Preliminary Draft of "Vocational Rehabilitation in Virginia." In this report you quite correctly noted that "vocational rehabilitation serves an important public function. Central to its purpose is a humanitarian interest in restoring the disabled individual so that he or she may be able to work again." In this important effort we need the help and support of every citizen of the Commonwealth. We feel that the recommendations contained in this report will be of value to us in our efforts to carry out this important mission.

Another important observation in your report is contained in the following statement:

"...the magnitude of difference between the eligible population (105,000) and the annual increment (15,000) and the persons rehabilitated by the Department of Vocational Rehabilitation indicates the Department cannot realistically serve all eligible persons with available resources."

This observation is tragic for those handicapped individuals who will not be served yet could be moved from a life of dependency to independence, removed from relief rolls, and become taxpaying citizens if rehabilitation services were provided. This critical need makes us particularly receptive to suggestions as to how the limited resources available to vocational rehabilitation can be utilized for a greater program impact.

While we are in substantial agreement with many of the recommendations and comments made in this draft report, there are some issues on which we have substantial differences. We hope that our comments will be read carefully and if they are judged to have merit that appropriate changes be made in this draft report.

Sincerely,

Altamont Dickerson, Jr.

Altamont Dickerson, Jr.
Commissioner

AD Jr:DRZ:s

Attachment

COMMONWEALTH OF VIRGINIA

DEPARTMENT OF VOCATIONAL REHABILITATION
RICHMOND, VIRGINIA

COMMENTS

on the

PRELIMINARY DRAFT
VOCATIONAL REHABILITATION
IN
VIRGINIA

As Submitted By The Staff
of the

JOINT LEGISLATIVE AUDIT AND REVIEW COMMISSION

November 3, 1976

INTRODUCTION

The Department of Vocational Rehabilitation has made a detailed review and analysis of the preliminary draft of the Joint Legislative Audit and Review Commission Report on "Vocational Rehabilitation in Virginia." We appreciate the opportunity to comment on the issues and concerns identified in this report. There are many valuable recommendations and observations contained in this report and the report is generally constructive and shows a good grasp of the rehabilitation program concept. However, there are a number of major issues and recommendations contained in this draft report on which we would like to comment.

BACKGROUND INFORMATION

In order for the concerns and recommendations contained in this report to be properly understood and be viewed in the proper perspective, it is necessary that some background information be provided regarding recent events in the Department of Vocational Rehabilitation.

In June 1975, the Board of Vocational Rehabilitation appointed a new Commissioner, Mr. Altamont Dickerson, Jr. He was given a mandate by the Board of Vocational Rehabilitation to bring about substantial programmatic changes and to improve the management practices within the Department. The Board was particularly concerned about the programmatic and management problems that had been identified in the numerous audits and reviews of the Department of Vocational Rehabilitation during the past two and one-half years. These audits and reviews included:

1. HEW Audit - "Review of the Vocational Rehabilitation Program administered by the Department of Vocational Rehabilitation, State of Virginia for the period July 1, 1972 to June 30, 1974."

   Report was received November 17, 1975. This comprehensive audit included both a program review and review of fiscal aspects of the program. It involved interviewing the staff at all levels and the provision of large amounts of data and other information. It also involved reviewing large numbers of case folders and interviewing staff of agencies that work with the Department.

2. Audit by the State Audit Office.
   This was primarily a fiscal audit of all fiscal transactions between June 30, 1972 and June 30, 1973.

3. Rehabilitation Services Administration Regional Office Audit.
   This audit was primarily a review of case folders using a random sample and concerned itself with all aspects of the rehabilitation process.

4. State Police Investigation.
   This investigation included interviews with staff, vendors and clients. It was initiated as a result of litigation in which former employees of this Department were accused of misappropriation of funds. This statewide investigation revealed no other problems of this nature.

5. Grand Jury Investigation.
   This investigation also was conducted as a result of alleged misappropriation

of funds by former employees of this Department. It involved interviews and testimonies by staff, clients and vendors.

6. GAO Audit of Sheltered Workshops.
Various staff persons were interviewed regarding services of Sheltered Workshops in the State.

7. Rehabilitation Services Administration - Program and Administration Review of SSI/SSDI Program.
This audit was completed January 1976 and we are now in the process of implementing many of the recommendations made in this audit.

This information is provided to give some insight into the scrutiny that has been given to the operations and management of this Department. These audits have been performed in addition to the internal audits which are performed as a matter of good administrative policy and the comprehensive overview now provided by the Board of Vocational Rehabilitation.

The accomplishments of the new administration of the Department in improving the Vocational Rehabilitation program have been substantial. Corrective action has been initiated or completed on problems identified in previous audits. It should be noted that the JLARC review came at a time of transition for the Department. We have a new administration, new priorities, a new management system and we are returning the program to working with those individuals who are traditionally physically and mentally disabled. It is our hope that the JLARC report will be read and interpreted with these facts in mind.

Management Actions

The Joint Legislative Audit and Review Commission's Preliminary Draft Report should clearly point out the major administrative actions which have been initiated to address many of the identified concerns and issues contained in this report. These administrative actions include:

(1) Management Systems Improvement.
A Federal Grant has been obtained to assist the Department of Vocational Rehabilitation in improving its management practices. The United Research Corporation of Orange, New Jersey, a management consulting firm has been employed to assist with this effort. The project is now underway and a number of significant improvements in management practices have been initiated.

(2) Manpower Utilization Study.
A major study of our manpower utilization has been completed and recommended changes have been made. These changes have resulted in a better utilization of our existing manpower and increased emphasis on the more severely disabled.

(3) Management and Planning System.
A comprehensive management and planning system has been implemented in the Department. The principle objectives of this system are:

1. To establish a management and planning system within the Department of Vocational Rehabilitation based on achieving identified objectives set for each level and unit of staff functioning.

2. To integrate planning, programming, and budgeting within the system based on identified needs, priorities and resources available.

3. To integrate employee performance review and assessment within the system.

While not yet fully implemented, this management and planning system will address many of the concerns in the JLARC report.

(4) New Programmatic Ventures.
A number of new program ventures have been initiated in cardiac rehabilitation, rehabilitation of the brain injured, rehabilitation of the deaf, and a number of other programs for the Severely Disabled.

(5) Establishment of a Program Evaluation Unit and an Internal Audit Unit.
These units have been established to evaluate and monitor the quality, efficiency and cost effectiveness of programs operated by the Department. Routine fiscal audits also are performed.

(6) Improved Operating Procedures Manual.
A major project has been initiated to review all client service policies and procedures. The outcome of this project will insure that all policies and procedures of the Department are appropriate, understandable and provide adequate guidance to our staff.

(7) Improved Communications and Cooperation with Other Agencies.
A major effort to improve cooperative working relationships with other agencies has been ongoing.

(8) Model Manpower.
The Virginia Department of Vocational Rehabilitation has initiated and is committed to a program of manpower training and development which will substantially improve the effectiveness and quality of services our staff is able to provide. Some of the elements of this program are:

1. Revised standards of performance.
2. Revised standards of professional preparation.
3. A career planning and development system.
4. Revised recruitment goals and strategy.
5. A revised system of induction and orientation training.
6. Continuing education for job enrichment.
7. Improved inservice training techniques.

MAJOR ISSUE CONCERNS

(1) Services to the Severely Disabled

The Preliminary Draft JLARC Report states that "DVR performance so far shows little concerted effort to serve the severely disabled. This is demonstrated by the proportionately fewer severely disabled rehabilitants by DVR in Fiscal Year 1975."

The Department takes strong exception to this statement. The facts simply do not support this generalization. It should be pointed out that the definition of the Severely Disabled used in the analysis of 1975 rehabilitants by the staff of JLARC is that mandated in the Rehabilitation Act of 1973. This definition does not necessarily reflect the difficulty of the rehabilitation effort or the relative need for rehabilitation services. The fact that this definition was applied to 1975 rehabilitants is in our opinion totally inappropriate and leads to a false conclusion.

The Rehabilitation Act of 1973 was signed by the President on September 26, 1973. Therefore, it was enacted during fiscal year 1974--a period in which the Agency was operating on a State Plan submitted in June of 1973 covering that fiscal year. Priorities, staff and resources had been developed and assigned on the basis of previous legislation and priorities. Cooperative agreements and relations with other agencies had been established in light of prior Rehabilitation Services Administrative directives and guidelines. It was on January 3, 1974 that the Social and Rehabilitation Services Administration issued interim regulations implementing the Rehabilitation Act of 1973. At this time, the Federal regulations were only beginning to deal with the problem of priorities of service to the severely disabled. There were substantial areas that were unclear both to the Agency and to Rehabilitation Services Administration (RSA) and the impact on other programs was not clearly defined. Please note on page 898, the following quote of the Interim Regulations:

> "These regulations are not intended to reflect a full implementation of the Rehabilitation Act of 1973."

The Interim Regulations further state:

> "a complete revision of regulations covering all Vocational Rehabilitation programs and activities under the Act will be published at a later date as a notice of proposed rule making."

Section 401.36, Order of Selection for Services, page 95 of the Federal Register, mentioned previously, states that while the State Plan shall set forth criteria in selecting handicapped individuals for services on the basis of serving first those individuals with the most severe handicaps, it also requires that the

> "State Plan shall further provide that services being provided to handicapped individuals under the terms and conditions of the Vocational Rehabilitation Act shall not be disrupted as a result of the approval of the State Plan under this part."

This means that cases in service are to continue to receive services even though priorities have changed. It was not until December 5, 1974 that RSA regulations implementing the 1973 Act were finally promulgated by the Federal Governments. (Note Federal Register, Vol. 39, No. 235) This was six months into the Fiscal Year 1975.

Please note Section 401.31, Order of Selection for Services, under the final regulations. While mandating the Order of Selection for the most Severely Disabled, Section D states:

"The State Plan shall further provide that no vocational rehabilitation services being provided to any handicapped person under the terms and conditions of the Vocational Rehabilitation Act shall be disrupted as a result of the approval of the State Plan under this part."

Virginia DVR had substantial numbers of people in service whose eligibility had been declared prior to December 5, 1974 and the Federal Guidelines required that continuity of services to these individuals be maintained. Therefore, the final regulations were published halfway through fiscal year 1975 and it was on the basis of these regulations that the performance of the Agency, in terms of serving the severely disabled, was judged by JLARC staff. Even if changes in regulations had not taken place, the closures of the Agency during 1974 and 1975 would have reflected casework practices and procedures in existence prior to that time. Individuals determined to be rehabilitated have completed rehabilitation services and some of these persons would have received services as many as four or five years. Therefore, eligibility and selection criteria for these individuals would have been based on prior guidelines and regulations prior to the Rehabilitation Act of 1973. Program changes to reflect emphasis on the severely disabled are only now being reflected in rehabilitations and it will take another year before the real impact of these changes is measureable.

The present number of severely disabled persons now being served by the Agency clearly reflects the increased emphasis the Department has placed on the severely disabled. On September 30, 1976, Agency records indicate that of 9,476 Virginians on our total caseload of 25,225 are classified as severely disabled. This is 37.5% of our caseload and differs considerably from the 24% severely disabled computed from the 1975 rehabilitants.

In summary, the data analysis of the severely disabled applies criteria and definitions that were not even in existence when many of the rehabilitated cases reviewed were accepted for services. The cases reviewed reflected RSA priorities and selection standards prior to the Rehabilitation Act of 1973. This inaccurate reflection of the Agency's commitment to serving the severely disabled should be deleted from your report.

(2) Cost of Rehabilitation Services to the Severely Disabled and the Mentally Ill

The JLARC Draft Report states on page 65 that "a major part of DVR fiscal year '76 Budget presentation to the Governor and the Budget Advisory Committee was based on claims that the mandate to serve the severely disabled would be a more difficult and expensive mission to perform. In the analysis of case cost, JLARC reviewed this claim and found it to be misleading and flawed."

This statement casts unwarranted doubt upon the good faith and judgement of the Agency in its attempts to deal with a difficult Federal mandate. The Agency values greatly its creditability with both the Governor's Office and the State Legislature and strongly objects to this statement. Furthermore, the facts do not support the conclusion reached by JLARC staff.

The position of the Agency is supported in the document "An Executive Summary of the Comprehensive Needs Study" published by the Office of Human Development, RSA, HEW. This study completed in 1975 was mandated by the

Rehabilitation Act of 1973. This document points out that increased costs are to be expected when services to the severely disabled are increased. The attempts to utilize 1974 and 1975 rehabilitant cost data, regarding the cost of serving the severely disabled, simply is not a valid approach for reasons previously stated. Furthermore, the cost data utilized by JLARC did not reflect the cost mandates contained in the 1973 Act or the true and total cost of these rehabilitants. It should also be noted that because of these new legislative mandates, demands for comprehensive rehabilitation services on the part of the severely disabled have opened up requests for home structural modification, modification of the work environment, van lifts, the building of ramps for accessibility, the expansion of services to the traumatically injured, the provision of tele-communication devices and other such services. These and other more sophisticated services have not traditionally been provided by DVR and will, of course, increase costs.

Perhaps even more important is the increased counselor time necessary to rehabilitate the severely disabled. Time is a substantial "cost" increase not given appropriate consideration by JLARC. If JLARC staff does, in fact, believe that the severely disabled are not substantially more costly to rehabilitation, then why, on page 140 of the Draft Report, is the statement made that "interviews with SSI counselors demonstrated that SSI clients generally are severely disabled and have no work skills or experience and are considered difficult and expensive to rehabilitate."

Appropriate attention simply was not given to the real and total cost of serving severely disabled persons. Attention is directed to the cost of mentally ill rehabilitants many of whom are severely disabled by Federal definition. JLARC cites, on page 47, a case cost expenditure for rehabilitants of $436 per case as compared to $674 for all cases. Approximately 50% of the mentally ill rehabilitants are generated in mental health units. Yet the cost of staff and other supportive services in the mental hospital units were not computed in the JLARC cost analysis. Staff for work adjustment service, training services and other vocational services represent a substantial expenditure that supplements the traditional mental hospital program. These services, when provided in the community, are purchased and reflected as case service expenditure but in the Institution they are <u>not</u> reflected as case service expenditure.

Therefore, if the total cost of mentally ill cases rehabilitated in our mental hospital units is computed correctly, the cost of the rehabilitation would be substantially more than the $436.00 cited in the JLARC Report.

Severely disabled clients and particularly seriously mentally ill persons are expensive to rehabilitate. Also, it should be pointed out that the number of severely disabled individuals provided rehabilitation services, but not rehabilitated, is a very substantial cost issue not considered in the JLARC Draft Report.

In summary, the assumption that severely disabled citizens in the Commonwealth will not be substantially more expensive to rehabilitate is in conflict with the facts, and this inference should be removed from the report.

(3) <u>Quality vs Quantity</u>

The Department is in basic agreement with the JLARC recommendation that the counselor accountability system should involve a system that gives full

attention to the quality of rehabilitation services provided. We have been struggling for a considerable time to come up with a workable "weighted closure" system that would not over encumber our counselors with additional non-productive paper work. To our knowledge no state rehabilitation program in the country has a workable, effective "weighted closure" system. While we will continue our efforts to install a "weighted closure" system, we are convinced that management philosophy is the key to correcting this problem.

The Department is proud that it has one of few social service programs that can be held truly accountable for program results. The Department is committed to insuring that high quality rehabilitation services are provided to eligible, vocationally handicapped individuals and that high quality is a part of our accountable system.

The problem of vocational rehabilitation counselors feeling pressure to "produce certain numbers of successful rehabilitants" is a problem of long standing in the rehabilitation community, not only in Virginia, but nationally. This is a problem about which the Board is also very concerned. This long standing problem of counselor attitudes regarding "pressure for rehabilitations" and the approaches utilized by some staff in this regard are receiving our serious attention. While such attitudes are difficult to change, we believe progress is being made.

The memo regarding production mentioned on page 143 of the JLARC report needs some clarification. The minimum standards mentioned in this memo were developed by a special committee composed of experienced counselors and supervisors in various types of programs throughout the state. They were not arbitrarily established by the administration of the Department. Based on the knowledge and experience of these counselors and supervisors, the minimum number of rehabilitations recommended to be produced is consistent with maintaining a high quality of rehabilitation services. Furthermore, they were developed in response to an articulated need by counselors, supervisors and other staff who wanted to have a standard against which to measure their productivity. These standards were developed to be used with common sense, taking into account special caseload considerations. Quality standards as outlined in our Policy and Procedures Manual were to be utilized in conjunction with these standards. These standards were intended to be temporary and replaced with a more sophisticated "weighted closure system." Our target date for implementing a "weighted closure system" on a pilot basis is January 1, 1977.

The report emphasizes the negative aspects of a "quota system." The conclusion that <u>could</u> be drawn from this report is that accountability for rehabilitation results is an undesirable part of the operation of the Department of Vocational Rehabilitation. We are confident that the State Legislature and JLARC share our desire that with the resources available, the maximum number of substantially handicapped individuals be provided <u>quality</u> rehabilitation services. Therefore, we suggest those sections of the report that seem to speak against accountability, or that could be interpreted as such, be revised to strongly stress appropriate accountability measures.

(4) <u>Establishment of Financial Responsibility</u>

The JLARC Draft Report on page 55 is somewhat critical of the financial needs test utilized by the Department, stating that the standards are too generous. It should be pointed out that there is no Federal requirement that a financial

needs test be utilized prior to the provision of DVR services. In fact, the Federal regulations prohibit a financial needs test from being applied to services provided to certain categories of clients - such as eligible Supplemental Security Income clients and eligible Social Security Disability Insurance clients. The regulations also provide that certain vocational rehabilitation services must be available to any eligible client without regard to individual resources. These services include (1) evaluation, diagnostic and related services, (2) extended evaluation services, except occupational and placement tools, (3) counseling and guidance, and (4) job placement and follow-up.

It should be clearly understood that the philosophy of the Virginia Department of Vocational Rehabilitation is that an individual should contribute to his rehabilitation effort what can reasonably be expected. However, we believe it is important that the Department take into consideration the present and future impact of disability on the financial resources of the family unit and that the complete savings and resources of the family not be depleted. It is also important that the assessment of financial need be done with consideration of the rehabilitation client's rights as an individual. Our policies state that when the available individual resources are sufficient to cover the cost of rehabilitation services, the client is not eligible for any financial assistance for his rehabilitation program from the Department. Many obligations and expenditures of the individual and/or family are considered but many obligations may not be allowable. Non-allowable obligations and expenditures are those considered non-essentials or luxury items. Where there is legally incurred debt for such items, the amount of monthly payment may not be used to determine the total allowable obligation. Our policies state that when an obligation or expenditure is unusual or above that which is normally required in the individual's community, it must receive special attention by the supervisor. However, JLARC has raised a valid question regarding the manner in which the Department establishes financial need. Our policies will undergo careful scrutiny and appropriate changes will be made to insure that the individual or his family contributes to his rehabilitation effort what is reasonable and fair. We anticipate our review of policies regarding the financial needs test will be completed by January 1, 1977.

(5) Changes in Income

The JLARC report on page 84 raises some interesting questions as to the Department's method of measuring the program's impact and these questions will be given serious study. It should be pointed out that the method of computing income prior to rehabilitation services, is prescribed by Federal guidelines - that is, the earnings to be recorded are for the week of referral. JLARC states they found one case that listed earnings the day before referral. This is not a correct procedure and because more than 55,000 cases are processed annually, we acknowledge that in isolated cases inaccuracies in reporting may occur.

The report also raised a question about the manner in which DVR measures program impact on handicapped school clients and institutionalized clients. This question is perhaps not without merit, however, the only way we can statistically and objectively deal with the question of what may have happened to these clients without DVR intervention would be to select a control group and not provide DVR services to them. In doing this, we would have some ideas of what the outcome might have been without DVR services. However, we are sure that JLARC would agree that this approach is totally unacceptable.

It is suggested by JLARC that long term income information, such as can be obtained by IRS Form 1040 or the Virginia Income Tax Return would be valuable in computing vocational rehabilitation impact on earnings. However, it should be pointed out that disability can substantially alter or eliminate the client's earning capacity. Therefore, in most cases Form 1040, which would reflect earnings prior to the onset of disability, probably would not be a valuable tool in computing DVR impact on changes in income.

In summary, we believe that the program impact of DVR is substantial and that dramatic increases in clients' earnings can be documented. We acknowledge that the recommended Federal approach is simplistic and does not take into consideration all the possible variables. Study will be given to developing a system for measuring program impact which is more comprehensive.

(6) Budget Administration

The Department has very stringent controls on expenditures in conformance with State accounting practices. During the period reviewed by JLARC there was at no time any question of an over expenditure being made in any budget category. However, JLARC is correct in pointing out that there is a need for better program-budget management and a need to develop and implement a functional budgeting system based on Agency practices and objectives. A program-budget system will be implemented as part of the total Department Management and Planning System (MAPS) currently being installed.

This report gives the impression that the Department was caught unaware and had to hurriedly call a moratorium on expenditures because it did not plan on clearly identified legitimate sources of revenue, particularly its special fund revenues. The Department made the decision to spend its unappropriated special revenues in the spring of 1975 when it was developing its biennium budget for FY 1976-78. This fact was spelled out in the budget document that was submitted to the Division of the Budget in August 1975. The Department was not made aware of the fact that there was any question as to its use of these funds until October 1975, four months into the fiscal year. By this time, our analysis of the rate of expenditures of case service monies indicated that unless we received these funds, which amounted to one million dollars, we would have to take drastic measures, which included a moratorium on expenditures. A decision was made in November 1975 to declare a moratorium on expenditures in December 1975, a month in which activity is historically low, in order to establish more stringent priorities and to await the decision from the Division of the Budget concerning the special fund revenues.

JLARC is incorrect in its observation on page 128 that the total amount that can be spent by counselors is not controlled. Each Region, each office within each Region, and each counselor has a yearly budget for case service and travel expenditures. It is true that the Regional Directors have authority to reallocate monies within their Region to meet priority needs; however, prior approval is obtained from the State Office for each transfer of funds made. However, JLARC is correct in its observation that a better reporting system is needed to provide counselors, on a more timely basis, their spending patterns in relation to their budgets. A new fiscal reporting system is under development in conjunction with the overall MAPS system mentioned previously.

I believe the material on pages 157 and 158 relating to unmet needs should be clarified. For example: You state that a total number of 5,778 clients between ages 15 and 64 are presently eligible for Vocational Rehabilitation services. According to our formula, 6,402 clients 14 years of age and older are presently eligible for Vocational Rehabilitation services. Please note that our formula includes all eligible clients including those over 65 years of age. You may want to review this section carefully since several conclusions were drawn from the figures which indicated that there is a substantial number of clients between the ages of 15 and 64 who are not receiving Vocational Rehabilitation services. It is our feeling that your projections of unmet needs within the working age population are quite high. It is also important to note that our formula is based on the 1970 census data and cannot be used for projections for 1966 to 1970. I will be happy to discuss this issue with you at your convenience.

Please be assured that we will make every effort to give priority to the working age population to increase the proportion of clients closed in competitive employment. However, I certainly hope that the General Assembly will be mindful of these efforts to the extent that additional General Funds will be required by the Vocational Rehabilitation and Rehabilitation Teaching Departments of this agency to increase services to the working age population and to continue providing comprehensive services to the elderly blind population. Elderly blind individuals are quite vocal in their demands for Vocational Rehabilitation services which are being provided at the present time and we cannot afford to leave a vacuum in our overall service delivery program.

During our recent meeting, you indicated that you were impressed with our efforts to obtain and maintain National Accreditation Standards in an effort to improve the quality and quantity of services to blind and visually handicapped individuals. You may want to elude to this in your final document if you deem it appropriate.

I wish to compliment the Joint Legislative Audit and Review Commission for a very thorough analysis of our program. I am quite impressed with the manner in which the review was conducted and with the high quality of staff assigned to the project.

Please let me know if you need additional information.

Sincerely yours,

William T. Coppage
Director

WTC/TCM:kcp
cc: Joseph H. Wiggins
Thomas C. Michael

JOINT LEGISLATIVE AUDIT AND REVIEW COMMISSION

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