STATE OF WEST VIRGINIA

PERFORMANCE AUDIT
OF THE

DIVISION OF REHABILITATION SERVICES

Rehabilitation Services Have a Positive Impact on Employment and Earnings of Individuals with Disabilities

Rehabilitation Center Inefficient Use of Resources

OFFICE OF LEGISLATIVE AUDITOR
Performance Evaluation & Research Division
Building 5, Room 751
State Capitol Complex

CHARLESTON, WEST VIRGINIA 25305
(304) 347-4890

WEST VIRGINIA LEGISLATURE

Performance Evaluation and Research Division

Building 5, Room 751A
1900 Kanawha Boulevard, East
Charleston, West Virginia 25305-0592
(304) 347-4890
(304) 347-4889 FAX

Antonio E. Jones, Ph.D.
Director

December 29, 1995

The Honorable A. Keith Wagner
State Senate
Box 446
Iaeger, West Virginia 24844

The Honorable Joe Martin
House of Delegates
Building 1, Room 213E
1900 Kanawha Boulevard, East
Charleston, West Virginia 25305

Gentlemen:

Pursuant to the West Virginia Sunset Law, we are transmitting the Performance Audit of the Division of Rehabilitation Services which will be reported to the Joint Committee on Government Operations at the January 7, 1996 interim meeting. The issues covered in the report are "Rehabilitation Services Have a Positive Impact on Employment and Earnings of Individuals with Disabilities, and Rehabilitation Center Inefficient Use of Resources." The report also includes the agency response from Mr. Bill Dearien, Director of the Division of Rehabilitation Services.

Sincerely,

John Sylvia
Research Manager

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Executive Summary

The Division of Rehabilitation Services provides a wide range of rehabilitation services to individuals with disabilities in West Virginia. A primary goal for the Division is to assist disabled individuals in overcoming the barriers they face in obtaining and maintaining competitive employment. The Division is the state entity responsible for administering the federal Rehabilitation Act of 1973, as amended. The federal government provides approximately $27 million to the Division for rehabilitation services, and the state provides a little more than nine million dollars, for a total budget of about $36 million.

Between 20,000 and 24,000 disabled individuals are served by the Division each year. Over 2,800 individuals are rehabilitated annually. Services are provided directly by the Division's staff, or services are purchased by the Division for individuals. Most of these individuals are served through the Division's seven district offices and 23 branch offices around the state. Services are also provided at the West Virginia Rehabilitation Center in Institute, West Virginia. Between 1,500 and 2,000 individuals from around the state are admitted to the Center each year to receive rehabilitation services.

In general, we found that the Division's services are sufficient in obtaining its desired goal of helping disabled individuals overcome the barriers to obtaining and maintaining employment. However, there are some concerns with respect to the inefficient use of the Division's resources. Below are brief descriptions of two issues raised in this report.

Issue 1: The Division's Rehabilitation Services Have a Positive Impact on the Earnings and Work Continuity of Individuals with Disabilities.

The analysis in this report compared the wage earnings and work continuity of rehabilitated individuals with the nonrehabilitated. The results indicate that individuals who successfully completed the Division's planned services experienced significant increases in wage earnings and work continuity compared to the period prior to receiving services. The nonrehabilitated, on the other hand, showed little change in earnings or work continuity during the period after their cases were closed. In 72% of the rehabilitated cases reviewed, wage earnings well exceeded the cost of rehabilitation. One area of concern was that some of the nonrehabilitated received substantial services, but were not rehabilitated. It is recommended that the Division examine why this occurs in a large number of cases.

Issue 2: **The West Virginia Rehabilitation Center and its Hospital are seriously underutilized, causing a disproportionate allocation of funds which should be available statewide.**

The Division spends 33% of its nonadministrative budget, or $9.6 million, to serve individuals at the West Virginia Rehabilitation Center located in Institute, West Virginia. However, the Center serves only seven to nine percent of the total number of individuals served by the Division statewide. This is a high commitment of resources to serve a relatively low number of individuals. Consequently, the average cost of providing services at the Center is seven times higher than the costs of services provided by the field program. Despite the low utilization of the Center, its budget has not been reduced to reallocate resources to the field program where most of the services are provided. **An effect of this disproportionate commitment of resources is that many field offices run out of case services money months before the end of the fiscal year.**

Also, the hospital unit within the Center has a rate of uncompensated services of over 70%. Part of the reason for the high uncompensated services is an inadequate effort to collect from third-party payers. The Division pays for the uncompensated services through its federal funding. This is an additional detraction of resources from field services. Furthermore, many of the inpatients served at the hospital have no record of being rehabilitated with an employment goal. This seems to be contrary to the primary intent of the federal program which is to empower individuals with disabilities to maximize employment and economic self-sufficiency. ***Overall, the Center is not cost-effective, and it seriously hampers achieving the objective of offering much needed services statewide.*** **However, PERD concurs with the DRS Strategic Planning Task Force which emphasized the importance of WVRC as an unique rehabilitation resource which needs to be providing "core services" as part of a carefully designed needs-driven regional network. This can be achieved through a commitment to redistributing resources, both staff and funding, from the WVRC to the Field Program.**

WEST VIRGINIA DIVISION OF REHABILITATION SERVICES

Audit Objective, Scope and Methodology

Audit Objective, Scope and Methodology

This performance audit of the West Virginia Division of Rehabilitation Services is required and authorized by the West Virginia Code in the "Sunset Law" (Chapter 4, Article 10). The Division is West Virginia's state entity responsible for administering the federal Rehabilitation Act of 1973, as amended. The purposes of the Federal Act are to empower individuals with disabilities to maximize employment, economic self-sufficiency, independence, and inclusion and integration into society.

The objective of this audit is to determine the effectiveness of the Division in achieving the purposes and objectives of the Federal Act. In particular, the primary focus is to measure how effective the Division has been in assisting the disabled in maximizing employment and economic self-sufficiency. Although independent living is another important purpose of the Act, it is not within the scope of the audit. The audit covers the time period from 1985 through 1995.

The analysis relied on the testimonies of the Division's administrative and field staff. Interviews were conducted with the staff in each of the Division's seven districts. Interviews also were held with officials of Workers' Compensation, the Department of Health and Human Resources, and nonprofit rehabilitation organizations. Various reports provided by the Division, and federal laws and regulations also were examined as part of the review. A sample of individual case files was compiled. The information within these files was kept confidential. The West Virginia Bureau of Employment Programs (BEP) gave permission to the Division to use its datalink with BEP to obtain wage data for the sample of individuals whose cases were closed in fiscal year 1992. These data were compiled and regression analysis was performed to determine the impact the Division's rehabilitation services had on the wages and work continuity of those rehabilitated by the Division in FY 1992. Every aspect of this audit complied with Generally Accepted Government Auditing Standards.

Issue 1: The Division's Rehabilitation Services Have a Positive Impact on the Earnings and Work Continuity of Individuals with Disabilities.

The Division of Rehabilitation Services (DRS) provides rehabilitation services to individuals with disabilities. The Division's goals are to offer services that:

1) Assist individuals with disabilities in overcoming barriers to obtaining and maintaining competitive employment.
2) Assist individuals with disabilities in achieving a greater degree of independent living.
3) Assist individuals with disabilities in becoming more socially integrated in today's society.

The following analysis attempts to measure whether or not the Division has achieved the first goal of assisting individuals with disabilities in obtaining and maintaining competitive employment. As the title of this issue indicates, the services provided by DRS appear to have a positive impact on the earnings and work continuity of individuals who were rehabilitated.

The Evaluation Approach

Individuals who apply for rehabilitation services and are determined eligible by DRS must have an Individual Written Rehabilitation Plan developed. This plan specifies the objectives, goals (such as employment), and rehabilitation services necessary to achieve the desired goals. Individuals who have employment as their goal are considered successfully rehabilitated if after completing their rehabilitation plan, they obtained and maintained employment for at least sixty days. It is quite common for individuals with a rehabilitation plan, to drop out of the program before their plan was completed. The Division closes these cases as nonrehabilitated.

The approach of this report was to compare the post-rehabilitation wage earnings of the rehabilitated with the wage earnings for the same period for individuals who were not rehabilitated. The nonrehabilitated were distinguished between whether they dropped out before or after they started their rehabilitation plan. This distinction is made because those who dropped out after their plan began usually received a significant amount of services. Individuals who dropped out before their plan was initiated will be referred to as nonparticipants, while those who dropped out after their plan was initiated will be referred to as partial participants.

The logic of comparing the employment outcomes of the rehabilitated with the employment results of the nonrehabilitated is in the important similarities between the groups. For example, each group expressed an interest in rehabilitation services by applying, was determined eligible for services by the Division, and all reached at least the point in the process of having a rehabilitation plan developed. These similarities are a good basis for making such comparisons.

The analysis recognizes that there are important differences between the groups that could

explain why the rehabilitated had better employment outcomes than those who were not rehabilitated. We cannot assume that the rehabilitated did better than the nonrehabilitated solely because they completed their rehabilitation plan. Other demographic factors could have also influenced the outcomes, such as prior work history. The analysis controls for some of these factors in order to isolate as much as possible the impact that resulted from the rehabilitation services.

The Sampling Process

A sample was taken from the groups of rehabilitated, partial participants and nonparticipants whose cases were closed in fiscal year 1992. The sample size was taken to account for a plus or minus five percent margin of error. The clients were selected randomly through a computer-produced random table. In FY 1992, 2,815 individuals were rehabilitated. A sample of 71 cases were taken from this group. There were 604 partial participants, which required a sample of 65, while nonparticipants totaled 487, requiring a sample of 63. The three samples combined totaled 199 cases.

We requested the Division of Rehabilitation Services to provide social security numbers in random order for the three groups for FY 1992 assigned to a sequential number. We then matched the random numbers with the sequential numbers associated with each social security number. This gave us the necessary number of social security numbers for the sample.

We received permission from the Bureau of Employment Programs (BEP) to allow the Division to access wage data pertaining to each social security number in the sample through the Division's datalink with the BEP. The wage data available were from the 2nd quarter of 1989 through the 2nd quarter of 1995, totaling 25 quarters. The period in which a client's case was closed is FY 1992, which includes the four quarters beginning with the third quarter of 1991 through the second quarter of 1992. This period (FY 1992) will be called the program period. There are nine quarters of wage data prior to FY 1992 which represents the pre-program period, and the 12 quarters (three years) of wage data following FY 1992 represents the post-program period. Wages earned out of state or from self employment were not available in the datalink since those wages are not required to be reported to the BEP. The case files for each client in the sample were provided by the Division to obtain other client information.

Of the sample of 71 rehabilitated, 21 were rehabilitated as homemakers or independent living. Of the 65 partial participants sampled, only 4 had a goal as homemaker or independent living in their rehabilitation plan, and finally of the 63 sampled from the group of nonparticipants, only 2 had a rehabilitation goal of homemaker or independent living. Those with homemaker or independent living goals generally did not have wage information for the post-program period. Therefore, they were excluded from the analysis.

Results of the Sample Analysis

Table 1 illustrates some of the sample statistics. Those rehabilitated were older than partial participants and nonparticipants by about eight years. A lower percent of the rehabilitated were categorized as severely disabled compared to the other two groups. The rehabilitated also had more pre-program work history, as indicated by the percentage of pre-program quarters worked. The total cost of services for the rehabilitated averaged $1,955 per client, while the averages for partial participants and nonparticipants were $2,169 and $326 respectively. Nonparticipants had a limited time in the program thus they had lower rehabilitation costs.

TABLE 1
Sample Statistics

	Rehabilitated	Partial Participants	Nonparticipants
Average Age	39.9	31.6	31.8
% Severely Disabled	44%	65%	51%
% Male	52%	60%	63%
% of pre-program quarters worked	43.8%	18.6%	28.4%
Avg. Rehabilitation Costs	$1,955	$2,169	$326

Table 2 provides additional information for clients within the sample on a pre and post-program basis. This comparison shows that the rehabilitated were the only group that had an

increase in the percentage of quarters worked, going from 43.8% in the pre-program period to 57.8% in the post-program period. Also, the average quarterly wage nearly doubled for the rehabilitated from the pre-program period to the post-program period. Partial participants also had sizable increases in average wage earnings over the pre-program period.

TABLE 2
Sample Statistics Pre & Post Program

	Rehabilitated		Partial Participants		Nonparticipants	
	Pre-Program	Post-Program	Pre-Program	Post-Program	Pre-Program	Post-Program
Avg. Quarterly Wages	$879	$1,720	$240	$757	$543	$711
% of Total Quarters Worked	43.8%	57.8%	18.6%	14.1%	28.4%	24.3%

The rehabilitated also earned, on average, about $1,000 more each quarter than the other two groups. However, we cannot attribute this wage differential entirely to rehabilitation services. We must factor for demographic variables that could have influenced the wage differential. To do this, regression analysis was performed which included a variable to distinguish the three groups, variables for age, gender, prior work history, and the disability status which distinguished between the severely disabled and those not severely disabled as indicated in the case files. The results and a detailed description of the analysis are contained in Appendix A.

Table 3 shows the estimates of the regression analysis for the average annual wage differential of the rehabilitated versus the other groups. Controlling for other factors, the rehabilitated earned on average $3,261 more than partial participants during the post-program period, and an average of $4,005 more than nonparticipants during the same period.

TABLE 3 Average Annual Wage Differential Post-program Period	
	Average Annual Wage Differential
Rehabilitated vs. Partial Participants	+ $3,261
Rehabilitated vs. Nonparticipants	+ $4,005

These data show that the Division's rehabilitation services contributed to higher wage earnings and longer work continuity for those who were rehabilitated in FY 1992. Those rehabilitated had higher wages than those in the other two groups before rehabilitation; nevertheless, wages for the rehabilitated increased following the rehabilitation period. The rehabilitated had a significant increase in quarters worked following rehabilitation in comparison with partial participants and nonparticipants who showed no significant increase in quarters worked in the post-program period. Also, the average annual wages for each of the three years in the post-program period were maintained, as illustrated in Table 4.

TABLE 4
Post-program Average Annual Wages
(unadjusted for inflation)

Rehabilitated			Partial Participants			Nonparticipants		
Year 1	Year 2	Year 3	Year 1	Year 2	Year 3	Year 1	Year 2	Year 3
$6,482	$7,109	$7,056	$2,390	$3,600	$3,099	$3,293	$2,819	$2,425

Caveats and Concerns

There are numerous variables that could explain why the rehabilitated had better employment outcomes than those who were not rehabilitated. We reemphasize that this analysis is a starting point. It is not intended to factor for every possible variable that could explain some of the outcome differences. We encourage DRS to conduct similar analyses in the future using other variables not included in this study. Furthermore, the wage data available through the datalink with the Bureau of Employment Programs do not include wages earned out of state,

or self-employment income. If a significant number of rehabilitated or nonrehabilitated had self-employment income or out of state wage earnings, the wage differentials estimated in this report would be over or understated.

The Division should be concerned that a large number of individuals received a substantial amount of services yet were not rehabilitated. In the case of partial participants, the sample indicates that the monetary value of services provided to them exceeded the monetary value of services provided to the rehabilitated, yet the partial participants experienced little impact from the services received. The number of individuals whose cases were closed nonrehabilitated after receiving substantial services in FY 1992 was 604. At an average cost of $2,169, the total estimated cost of services provided to these individuals was $1,310,076.

Another concern involves the criteria for determining successful rehabilitation. As stated previously, an individual with employment as a goal is considered rehabilitated if, after completing a rehabilitation plan, employment was maintained for at least 60 days. The use of this criteria is required by federal law. From a cost-benefit point of view, a critical criteria of success would be if wage earnings eventually exceeded the costs of rehabilitation. The 60-day criteria would show in many cases that the cost of rehabilitation exceeds the wages earned by the rehabilitated because the average wages earned in 60 days is usually less than the average rehabilitation costs. **However, the good news from this study shows that 72% of the rehabilitated worked long enough that their wage earnings well exceeded the costs of rehabilitation.**

In addition, the 60-day criteria does not adequately measure work continuity. Although there was a marked increase in the percentage of quarters worked in the post-program period, the study indicates that over 40% of the quarters recorded no earnings. This suggests that many rehabilitated individuals did not experience a relatively long work history during the three years following rehabilitation. The Division is encouraged to routinely conduct long-term impact studies using comparison groups. As far as we can determine, the Division has not conducted such studies.

Recommendation 1

We recommend that the Division of Rehabilitation Services conduct periodic long-range outcome evaluations. These evaluations should measure the success of the program over a long wage history that can better judge work continuity than the 60-day criteria allows. Comparison groups should be used in the evaluation as was used in this analysis. The Division should test additional demographic variables not used in this study. Also, a cost-benefit analysis of rehabilitation services should be conducted as part of the periodic evaluation.

Recommendation 2

The Legislature should consider statutory changes that requires the Division to submit

long-range outcome evaluations to the Legislature.

Recommendation 3

We recommend that the Division examine why a large number of individuals receive substantial services yet are not rehabilitated. The Division should determine the number of these individuals, why these individuals dropped out of the program, the costs of providing services, and other characteristics that could remedy this condition.

Issue 2: The West Virginia Rehabilitation Center and its Hospital are seriously underutilized causing a disproportionate allocation of funds which should be available statewide.

The West Virginia Rehabilitation Center (WVRC) and within it the hospital are located on a 35 acre campus in Institute, WV in 12 acres of totally accessible, interconnected buildings. The comprehensive rehabilitation facility is fully accredited by the Commission on Accreditation of Rehabilitation Facilities and the North Central Association of Colleges and Schools. Programs include vocational evaluation, vocational-technical training, personal adjustment services, developmental education, and medical rehabilitation. Work adjustment services were provided until May of 1995; it was closed because the services at the center were underutilized and were available in the community.

In order to qualify for reimbursement from third party sources such as Medicare, Medicaid, and private insurance companies, the Division of Rehabilitation Services (DRS) spent approximately $1.5 million upgrading both the staff and the physical plant of the facility to meet standards required for hospital licensure and third party reimbursement. The license was granted in 1990. The hospital is licensed as a comprehensive rehabilitation hospital by the State Health Department and accredited for its medical services by the Commission on Accreditation of Rehabilitation Facilities (CARF). The 40 bed hospital/medical unit provides rehabilitation nursing services on a 24 hour basis and student health services for sick call and medical maintenance/management. Professional services include primary medical services, physical and occupational therapy, speech and audiological services, radiology, laboratory, dental, and pharmacy services.

Objectives and Goals of the Rehabilitation Act of 1973 as Amended.

The Federal Rehabilitation Act of 1973, as amended, specifies several objectives to be obtained in carrying out the mission of providing rehabilitation services under the act. Some of these objectives are listed below:

1) Provide comprehensive rehabilitation services in a cost-effective manner.
2) Utilize community-based rehabilitation programs to the maximum extent feasible.
3) Allow individuals receiving rehabilitation services to be actively involved in making choices about the selection of rehabilitation services that they will receive.

The Division falls short of obtaining these goals with respect to the operation of the rehabilitation center for several reasons. The following list gives a brief discussion of the current conditions which are inconsistent with the objectives of the federal rehabilitation act.

Current Conditions Inconsistent With the Rehabilitation Act's Objectives

1) The average cost to serve individuals at the WVRC is seven times higher than the average costs of serving individuals through the Division's field offices. This is illustrated in Table 5.

TABLE 5
TOTAL EXPENDITURES PER PERSON SERVED
WVRC AND FIELD PROGRAM

Fiscal Year	Field Offices	WVRC
1995	$937	$6,316
1994	$864	$5,519
1993	$835	$4,712
1992	$860	$4,864
1991	$820	$4,529
1990	$673	$4,233

2) The WVRC serves only seven to nine percent of the total number of individuals served by the Division statewide. This is illustrated in Table 6.

Table 6 Percentage of Total Served and Total Successful Rehabilitations Served at the WVRC				
Fiscal Year	**Total Served by DRS Statewide**	**% Served at WVRC**	**Total Successful Rehabilitations Statewide**	**% Successful Rehabilitants Served at WVRC**
1995	20,676	7%	2,934	9%
1994	20,759	8%	2,824	9%
1993	22,385	9%	2,866	10%
1992	21,000	9%	2,815	10%
1991	20,669	9%	2,804	10%
1990	21,136	8%	2,782	10%

3) The budget for the WVRC is approximately 33% of the Division's nonadministrative budget. This indicates that 33% or $9.6 million is used to serve only seven to nine percent of the Division's clients, while only 65% of the nonadministrative budget or $19.3 million is used to serve the remaining 93% of the Division's clients. This is illustrated in Table 7.

TABLE 7 Field & WVRC Budget				
FY	Field Budget	Total Served	WVRC Budget	Total Served
1995	$19,366,416	20,676	$9,600,455	1,520
1994	$17,926,165	20,759	$9,459,803	1,714
1993	$18,697,080	22,385	$9,424,886	2,000
1992	$18,071,084	21,000	$9,430,736	1,939
1991	$16,938,979	20,669	$8,749,822	1,932

4) The hospital unit within the Center has a rate of uncompensated services in excess of 70%. The hospital costs about $2.9 million to operate. This funding comes primarily from the Basic grant funds received from the federal government to administer the Rehabilitation Act. The hospital serves on average between 100 to 125 inpatients each year at an average cost of over $26,000. In many of the case files sampled for FY 1994, there was no record available that any of these individuals were rehabilitated with a competitive employment goal by the Division's criteria.

5) In order to justify the existence of the Center, DRS has placed an emphasis on the field program utilizing the Center even in cases where the services are offered by community-based programs. This potentially violates the principle of giving individuals an active choice as to where they will receive rehabilitation services. Furthermore, the emphasis to use the Center regardless of whether the services are available in the community, does not facilitate the development of community-based programs, which is an objective of the Rehabilitation Act.

6) Close to half (47.7%) of the total number of individuals admitted to the Center come from the seven-county district in which the Center is located (which contains only 20% of the state's population). This is a disproportionate commitment of resources considering the needs statewide and a "statewideness" requirement in Title I of the Rehabilitation Act.

Causes for Inefficiency and Ineffectiveness of the WVRC

The Division claims that the Center serves a higher proportion of the severely disabled than the field offices to explain the higher costs. PERD acknowledges that the WVRC serves a higher proportion of the severely disabled than the field. Over the past six years, 70% to 80% of the successful rehabilitants who were served at the WVRC were severely disabled. For the same period, 50% to 54% of those served through field services who achieved successful rehabilitation were severely disabled.

While the higher percentage of severely disabled served at the WVRC could account for some of the higher costs, PERD contends that two other factors are the major reasons for the higher costs. These are:

1) The *underutilization of the Center* which is partially the result of the same services being more available at the community level than in the past.

2) A *high rate of uncompensated care* at the hospital unit within the Center which is the result of an inadequate effort to bill third party payers.

Task Force on the Rehabilitation Center

The Director of DRS appointed a special Task Force on Strategic Planning for the

WVRC which submitted their report on July 29, 1995. The 18 member Task Force was composed primarily of DRS employees. Although the Task Force commented on the "sense of estrangement" which "appears to have developed between WVRC and the Field Program over the years" and "the resulting disadvantages for effective collaboration and coherent programming," they emphasized the importance of WVRC as a unique rehabilitation resource. The Task Force cautioned that strategic planning for the center has no purpose unless it is "integrated with and supportive of the Division's strategies." They recommended eight principles to guide the Division's strategic planning for the Center for the next five years. The principles emphasized a significant shift from centralized to decentralized services provided at either the community level or through regional service networks structured to meet identified needs with practical and cost-effective methods. The first principle is that the Center strive to address three primary missions:

- A statewide mission for identified core services;
- A regional mission as part of any "one-stop-shopping system"; and
- A research and development mission to support other regional centers.

Basically, the Task Force challenged WVRC to avoid duplicating services which are otherwise available at the community level throughout the state and focus on developing core services not available elsewhere in the state.

Low Utilization of WVRC

PERD found through site visits and interviews with field offices and community-based rehabilitation programs an impressive network of rehabilitation services. Some of the services which are being effectively provided at the district level by DRS are still being provided at the Center. For example, DRS has vocational evaluation units at the District office level which are effective and more readily accessible to clients, staff and others in the community. In the Lewisburg District, the Vocational Evaluation staff travel to locations throughout the District which makes the service available to clients in rural areas. The Evaluation Unit in the Beckley District Office has been generating income from services provided to other agencies and even local lawyers. The Comprehensive Rehabilitation Unit at the Clarksburg District Office has equipment for work hardening/simulation which is not even available at the WVRC.

The low utilization of the Center is reflected in statistics on use of the dormitory which has a total capacity of 308. The WVRC Registrar stated that the 52 rooms on the third floor are reserved for interns and guests. The average monthly occupancy dropped from 52% in FY 91 to 40% in FY 95. During October 1995, the WVRC training/service programs were operating at 77% of their capacity. In addition, effective June 1995, the Work Adjustment unit closed due to a decline in enrollment. The Division cited the availability of work adjustment services at the community level as the reason for declining enrollment.

A significant cost factor for the Center in general is operating the Rehabilitation Hospital or Medical Services Unit which is located within the Center. During FY 94 the hospital, with a budget of $2,615,681 served 97 inpatients with an average cost per patient of $26,966. The

hospital has been licensed for 40 beds since 1991 but usually operates at around 50% to 55% occupancy. The Hospital Administrator stated during an interview that approximately 20% or 343 of the students in FY 94 utilized the Medical Services Unit primarily through the outpatient Student Health Services and specialty clinics during their stay at the Center. The reasons given for this underutilization are primarily the cost of recruiting the professional staff required to comply with the licensing requirements and the lack of revenue due to the level of uncompensated care which ranges consistently from 70% to 80%. The average patient stay is 30 to 40 days, and there are currently 29 individuals on the waiting list for admission to the hospital.

Within current operating practices, DRS cannot justify filling the hospital to capacity with inpatients because they foresee no way to cover the cost of providing the services. The Hospital has been licensed since 1991 to bill third party payers such as Medicare Parts A and B, Medicaid, private insurance, and Workers' Compensation. From 1991 through 1995, the Division has been utilizing only one full-time staff member and a part-time contract employee for the medical services billing process. The billing process has remained primarily an outdated manual process until late in FY 95 when the electronic accounts receivable program was installed on the newly established Medical Services network. PERD acknowledges the positive movement but does not believe that this demonstrates an adequate or timely commitment to the recovery of fees for services rendered needed to offset the cost of operating as a fully licensed comprehensive rehabilitation facility. The total amount of revenue recovered by the hospital unit from third party payers from FY 91-95 was $1,483,939 compared to the total budget of $12,051,427 for a 12% recovery rate.

Effects of the Inefficiency of the WVRC

A major effect of the declining enrollment at the Center and the high uncompensated services rate is a disproportionate commitment of resources. Obviously, if the hospital unit were more self-sufficient, more rehabilitation funds would be available for other services at the field level or the Center. Interviews with field staff and Division administrators have confirmed that one result of this disproportionate commitment of resources to the Center operations is that the field staff regularly run out of case services funds three to four months before the end of each fiscal year. This pattern has continued for the past four to five years. This means that the field counselors have very few or no case service funds for at least three months out of every 12 to serve 91% of DRS clients served by the Division, while services at the Center continue uninterrupted for the nine percent served there. Interviews with community agencies also confirmed the existence of the recurring funding problems during the last quarter of the year especially with respect to the supported employment program.

The 1992 Amendments to the federal Rehabilitation Act emphasized the principle of "informed client choice" and an increased emphasis on developing and using community rehabilitation programs. PERD believes that the disproportionate commitment of funds to the operation of WVRC is in direct conflict with the intent of the federal direction. This conflict is clear in Attachment 8.3A to the 1994-95 *West Virginia Division of Rehabilitation Services Title*

I State Plan. On page one of the Plan is the Informed Choice process which emphasizes that an individual's choice may include choice of training facility and choice of geographic location where their services will be provided. On page two of the same document is the statement that it is the **"Division's policy to maximize the appropriate utilization of staff and other resources internal to the Division in providing services, including staff and other resources of the West Virginia Rehabilitation Center. As an example, the Division does not purchase services from other rehabilitation facilities unless the Division has determined that the needed services cannot be appropriately provided by the West Virginia Rehabilitation Center."**

This statement appears to include purchasing services from community rehabilitation programs. DRS funding for Community Rehabilitation programs for FY 95 was approximately $1.9 million. There are 35 community work centers that are non-profit organizations which provide sheltered work, work adjustment, supported employment, and employment. During FY 95, the Community Work Centers served 2,709 individuals with disabilities throughout the state. DRS utilized $339,284 in Section 110 Case Services funds to purchase extended employment services for approximately 694 clients at the community work centers throughout the state. In addition, DRS provided Basic Services grants of approximately $20,400 to each work center to supplement the cost of core administrative staff. The combination of services purchased from community-based facilities and the $1.9 million funding equals $2.4 million or 6.8% of the total DRS FY 95 budget of $35 million. With the significant and increasing commitment of funds to WVRC operating costs there are no funds available from DRS for further support of developing or expanding community rehabilitation programs. PERD finds that this is inconsistent with the statement submitted as part of the Title I State Plan submitted to the federal government which indicates that DRS "utilizes community rehabilitation programs to the maximum extent feasible to provide vocational rehabilitation services to individuals with disabilities...".

It should be noted that the Division has stated to PERD via memorandum that the Division's policy in the use of the Center is changing. It is the intention of the Division to focus primarily on providing services at the Center when there is a general absence or inadequacy of such services statewide, and this absence impedes the rehabilitation of persons with the most severe disabilities. PERD agrees with this policy change; however, the progress in this area appears to be relatively slow.

In addition to the low commitment of staff necessary for effective third party billing, PERD finds that there appears to be no organized marketing effort to identify present and potential customers' needs. For example, although there is an existing cooperative agreement with the WV Workers' Compensation Division, there doesn't seem to be any active effort to recruit more Workers' Compensation cases or to capture the business which is being directed to private rehabilitation providers who charge rather expensive rates. The cooperative agreement which is currently in place binds the Division to providing services such as developing the individual rehabilitation plan for Workers' Compensation claimants at no cost to Workers' Compensation. Workers' Compensation is paying $50 to $60 an hour to private rehabilitation vendors for the same services. DRS should review this situation given the cost of operating the Center and the strained field services budget.

Conclusion

During FY 1994, the Center served 1,714 students with a total budget including the hospital of $9,459,803. For this same period of time, the Field Services Program served 20,759 individuals with a total budget of $17,926,165. The Division has committed approximately 42% of the total Division staff to operating the Center with 40 % committed to Field Services and the remaining 18% to Administration. This reflects a disproportionate commitment of both staff and funding resources to providing services at the Center for only nine percent of the total number of individuals with disabilities that they served. This disproportionate commitment of resources is further highlighted by the comparison of the total budget and total number served contained in Table 7. Note the increase in the WVRC budget as the total number served declined from FY 93 through 95.

PERD concurs with the recommendations of the DRS Strategic Planning Task Force that emphasized the importance of WVRC as a unique rehabilitation resource which needs to be providing "core services" as part of a carefully designed needs-driven regional network. These "core services" must be those that either cannot be provided in a cost-effective manner at the community level or are so highly specialized that a general absence or inadequacy of such services statewide impedes the rehabilitation of persons with the most severe disabilities. PERD concludes that the current operation of the Center is inconsistent with the Center's stated mission of providing "comprehensive rehabilitation services in a cost-effective manner to Division clients and other persons with disabilities to improve employability and enhance independence." The cost of operating the Center requires additional federal Title I funds each year to cover the basic fixed costs. This in turn drains funding away from the field services program where the majority of the Division's clients are served. **With a commitment to redistributing resources, both staff and funding, from the WVRC to the Field Program, DRS has the expertise to provide more effective and timely services. This can be accomplished at the community level or in combination with a network of regional centers/service networks to support additional successful employment outcomes for individuals with disabilities.**

Recommendation 4

PERD recommends that DRS: (a) determine what services should be provided at the WVRC which are not available at the community level; (b) identify alternate funding sources for the Center; (c) phase out direct funding for the Center, shifting those funds to the field program and requiring the Center to compete for field services funds; (d) develop and submit a plan to the Joint Committee on Government Operations relating to this recommendation by December 1, 1996.

Recommendation 5

PERD recommends that the Division renegotiate the current cooperative agreement with the Workers' Compensation Division to include payment for case management services including at a minimum the initial evaluation and the Individual Written Rehabilitation Plan development process. A copy of the revised agreement is to be submitted to the Joint Committee on Government Operations by June 15, 1996.

APPENDIX A

Regression Model

Two regression models were constructed which included control variables for the demographic differences. Model 1 compared the wage earnings of the rehabilitated and the partial participants, and model 2 compared the wage earnings of the rehabilitated and the nonparticipants. The dependent variable for both models was the average annual wage earnings for the post-program period for the respective groups being compared in each model. The independent variables were the same for both models. They included age, gender, status, work history (number of quarters worked pre-program), and disability status. The values for the independent variables are shown below:

STATUS= Model 1: 1 (Rehabilitated); 0 (Partial Participants)
Model 2: 1 (Rehabilitated); 0 (Nonparticipants)

AGE = Age in years.

GENDER = 1 (Male); 0 (Female)

WORK HISTORY= 0 - 9 (Number of pre-program quarters with earnings)

DISABILITY STATUS= 1 (Severely Disabled); 0 (Not Severely Disabled); This is according to the Division's case files.

For comparison purposes, the status variable simply distinguishes between the rehabilitated and the other two groups. The number of demographic variables that could be included in the model are numerous. This analysis is not intended to account for every variable that could explain differences in employment outcomes such as education and race.

The results of the regression analysis are illustrated in Table 8. All the variables were statistically significant at the five percent level with the exception of the age variable and the disability status variable. Controlling for some demographic differences revealed that on average the rehabilitated earned $3,261 more than partial participants during the post-program period, and $4,005 more than non-participants for the same period. The analysis suggests that disability status and age did not account for differences in wages for the sampled population. While gender, work history, and the successful completion of a rehabilitation plan did have a positive impact on an individual's wages.

TABLE 8
Regression Analysis Results

	Partial Participants Model	Nonparticipants Model
STATUS	3,261 (1,629)	4,005 (1,255)
SEX	3,358 (1,530)	2,901 (1,260)
AGE	11 (65)	-76 (53)
DISABILITY STATUS	653 (1,645)	-649 (1,282)
WORK HISTORY	439 (267)*	391 (195)

Figures in parentheses are the standard errors of the coefficient estimates.
All variables were significant at the 5% level except AGE and DISABILITY STATUS in both models.
*significant at the 10% level.

Appendix B

Record of Interviews

Barbara Harmon-Schaumberger, Cabinet Secretary
Department of Education and the Arts

Rehabilitation Services Administration, Washington D.C.

Keith Beichner, Vocational Rehabilitation Program Specialist, Region 3, Philadelphia, PA.

Charles Sadler, Vocational Rehabilitation Program Specialist, Department of Education, Washington, DC.

Division Staff

Institute, West Virginia

William C. Dearien, Director

James E. Jones, Deputy Director, Program Operations

Michael T. Smith, Deputy Director, Administration

John P. Harrision, Assistant Director, Field Services

Frank Tolliver, Assistant Director, Resource Management

Daniel Greene, Chief, Fiscal Affairs

William Tanzey, Administrator, West Virginia Rehabilitation Center

Steve Hill, Administrator, West Virginia Rehabilitation Center Hospital

Charles Lovely, Chief, Special Services

District 1 - Charleston

Karen Poindexter, Supervisor/Rehabilitation Counselor
Institute Branch Office

District 2 - Clarksburg

Larry Bell, District Manager

Thomas Nuzum, Manager
Comprehensive Rehabilitation Center

District 3 - Wheeling

Robert Kinnick, District Manager

Cynthia Woody, Branch Office Supervisor
Parkersburg Branch Office

Frank Collelo, Rehabilitation Counselor
Weirton Branch Office

District 4 - Beckley

Danny Cole, Acting District Manager

Susan Baldwin, Rehabilitation Counselor
Beckley Branch Office

Moody Waddell, Rehabilitation Counselor
Beckley Branch Office

District 5 - Huntington

Dwight McMillion, District Manager

District 6 - Martinsburg

James Ganoe, District Manager

Robert Burke, Senior Rehabilitation Counselor
Bonnie Mason, Rehabilitation Counselor
Martinsburg Branch Office

District 7 - Lewisburg

Ezra Lilly, District Manager

Jeff Myers, Rehabilitation Counselor,
Nancy Harris, Rehabilitation Counselor
Lewisburg Branch Office

Paul DiBacco, Branch Manager,
Sandra J. Carr, Rehabilitation Counselor
Bion J. Manning, Rehabilitation Counselor
Elkins Branch Office

Community Programs and Other Representatives

Boris Kachura, Assistant Director, Planning & Reporting, General Accounting Office, Washington, DC

Kathy Neil, Office of Auditor General, State of Florida, Tallahassee

Judith Frye, Director, Wisconsin Legislative Audit Bureau, Madison

Richard Walls, Director, WVU Rehabilitation Research and Training Center, Morgantown

Don Cross, Area Administrator, Disability Determination Section, Clarksburg
Gail Mihaliak, Rehabilitation Prograrm Specialist, Disability Determination Section, Clarksburg

Sharon Paterno, Director, Family Support, Division of Human Services, Charleston

Ann Stottlemeyer, Director, Office of Medical Services, Department of Health and Human Resources, Charleston.

Auburn Cooper, Director, Primary Care Unit, Office of Medical Services, Department of Health and Human Resources, Charleston

Brenda Hellwig, Director, Summit Job Squad, Clarksburg

Ms. Sammy Burdette, Director of Development, SW Resources, Inc., Parkersburg

Susan Edwards, Executive Director, Client Assistance Program, Charleston

Lee Dixon, Executive Director, Buckhannon-Upshur Work Adjustment Center, Buckhannon,

Dot Gioulis, Executive Director, Precision Services, Inc., Sutton,

Judy Beckett, Executive Director, and Vicki Tambling, Director, Client Services Goodwill of KYOWVA, Inc., Huntington

James A. Smith, Acting Supervisor, Rehabilitation Services Section, WV Workers' Compensation Division, Charleston

David Eakle, Executive Director, Green Acres Regional Center, Inc. Lesage

Barbara Judy, Project Manager, Job Accomodation Network, Morgantown
Chairperson, State Rehabilitation Consumer Advisory Committee

Lori Stark, Program Coordinator, Hagerstown Goodwill Industries, Inc., Martinsburg

Gail Lucas, Economic Services Supervisor, Department of Health and Human Resources, Martinsburg

Darcia Collis, Acting Supervisor, Employment Services, Department of Health and Human Resources, Martinsburg

Inetta Arborgast, Independent Living Skills Specialist, Northern WV Center for Independent Living, Elkins

Joel Galperin, Executive Director, Eastern Panhandle Training Center, Martinsburg

Frederick Donovan, Executive Director, East Ridge Health Systems, Martinsburg

Bob McCoy, Director, Seneca Designs, Elkins

Mark Jenkinson, Attorney, Member, Martinsburg Consumer Advisory Committee, and Member, State Independent Living Advisory Committee

Ralph Quinn, Member, Martinsburg Consumer Advisory Committee, and Member, State Independent Living Advisory Committee.

Appendix C

WEST VIRGINIA DEPARTMENT OF EDUCATION AND THE ARTS
DIVISION OF REHABILITATION SERVICES
WILLIAM C. DERRIEN, DIRECTOR

December 29, 1995

Mr. John Sylvia, Research Manager
West Virginia Legislature
Performance Evaluation and Research Division
Building 5, Room 751A
1900 Kanawha Boulevard, East
Charleston, West Virginia 25305-0592

Dear Mr. Sylvia:

Thank you for sharing with me a copy of the performance audit of the Division of Rehabilitation Services pursuant to the West Virginia Sunset Law. Our meeting with you, Susan Beard, and Dennis Rhodes on Friday afternoon, December 22, 1995, was helpful to me and my staff in clarifying and understanding the more salient issues contained in your report.

We are pleased that many of our own views of the strengths and weaknesses of our program are validated by your report. It is gratifying to have reinforced the value of our services through your findings that successful rehabilitation services do result in real economic gains by rehabilitated individuals.

We recognize the deficits identified in your report and have begun developing and implementing changes of policy and program to address them. As you well understand, many changes may be as difficult to implement as they are necessary, and we would welcome legislative support in carrying forward some of the more difficult decisions that must be made. To that end, we would welcome another meeting with you and your staff, following your final report, to jointly consider our plans for further action.

Some of the initiatives for our field program which are already in progress were reviewed in my Director's Letter to Division staff of December 12, 1995 (enclosed). Along with improving our Division's approach to management planning, issues addressed by that letter included the following:

STATE CAPITOL • P. O. BOX 50890 • CHARLESTON, WEST VIRGINIA 25305-0890
(304) 766-4600 • FAX (304) 766-4671

- Focus on Employment Outcomes
- Counselor Empowerment
- Building Partnerships and Alliances
- Informed Client Choice
- Cost-Effectiveness and Efficiency
- Reallocation of Resources
- Measuring Program Outcomes/Benefits

In my more recent Director's Letter of December 28, 1995 (also enclosed), I specifically addressed your concern regarding maximum utilization of community resources.

I especially hope to explore with you in greater detail your recommendations regarding utilization of the West Virginia Rehabilitation Center (WVRC), including the West Virginia Rehabilitation Hospital.

To implement change effectively requires a common vision for the future. We are currently working to develop a consensus among our constituencies regarding the specific core services that will serve as the fundamental basis for our Center operations.

The West Virginia Rehabilitation Center was established in 1955 when there was no statewide system of behavioral health centers. Vocational-technical centers were in the early development stages. There were no regional rehabilitation hospitals. No network of community rehabilitation programs. Over the past few years, these programs have emerged in our communities and have impacted dramatically on the availability of services at the community level. At the same time, however, changes in trauma responses and medical treatment and technology enabled persons to live with conditions that would have resulted in death in prior years. Such occurrences have dramatically changed the concept of disability and the types of services needed for individuals to function in the community. High degrees of specialization, professional expertise, and technology will be necessary to rehabilitate these individuals. These individuals should be the new target for the West Virginia Rehabilitation Center's service delivery system. In order to move in that direction, it will take considerable reshuffling and reallocation of resources.

We share your concern about the strategic allocation of resources between the field program and WVRC, and fully intend that our work in implementing the recommendations of the Task Force on Strategic Planning for WVRC will result in a major

step toward resolving this imbalance. This approach may result in identifying needs to downsize or eliminate particular programs/services. However, as we experienced during recent efforts to revise WVRC vocational-technical training services, the understanding and active support of our State Legislature would be essential for success.

WVRC does, and likely will, continue to require a substantial investment of funding and human resources. Nonetheless, given the extremely rural nature of our state, WVRC also is, and we believe, must remain a unique rehabilitation resource for West Virginians with disabilities. The challenge is to ensure the best, most cost-effective utilization of that resource while also supporting maximum utilization of other rehabilitation-related resources within the community. It is a challenge which we fully accept, and we look forward to your continued assistance as we move forward in this endeavor.

Kindest regards,

William C. Dearien, Director

Enclosures

CC: Barbara Harmon-Schamberger

PROGRAM EVALUATION

for

WVDRS

To be conducted by

The WV Rehabilitation Research & Training Center

1996

Objectives

Rehabilitation Act, Section 101(2)(5)(15) and (19) requires WVDRS to assess the effectiveness of the services it provides to its citizens with disabilities. The study is targeted to meet that requirement. The project will carry out the program evaluation of WVDRS services by (a) planning and devising a set of measures covering input, process, and outcome variables, (b) using those measures to gain the necessary data for analyses, and (c) reporting evaluative interpretations in terms of coverage, efficiency, and effectiveness. Key Output Indicators reflecting the performance of the VR Program in West Virginia will be identified, analyzed, and evaluated as they relate to Contributing Factors from input and process stages. Such indicators will be derived using the interactive model of input-process-output variables. This model will be based on hard data collected at the WVDRS Field and Rehabilitation Center program sites.

Specifically, the model will be based on eight Key Output Indicators and seven subcategory Key Output Indicators for SD. These will be related (to the extent possible) to Contributing Factors such as client characteristics, service characteristics, and economic environment characteristics at input and process stages of vocational rehabilitation. These proposed Key Output Indicators are:

1. Rehabilitations per 100,000 population
2. Rehabilitation rate
3. Percent of closures with an employment outcome (proposed RSA standard)
4. Percent of employment outcomes in a competitive setting (proposed RSA standard)
5. Percent of individuals who are placed in competitive employment who have medical insurance available to them through their employment (proposed RSA standard)
6. Average cost per case
7. Average cost per rehabilitation
8. Average gain in earnings
9. Average gain in percent with earnings
10. Weekly earnings at closure for those individuals who have achieved a competitive employment outcome (proposed RSA standard)
11. Percent of individuals closed in status 26 or 28 who are satisfied with their level of participation in decision-making about vocational goals, services, and service providers. (proposed RSA standard)

12. Percent of individuals closed in status 26 or 28 who are satisfied with the appropriateness, timeliness, quality, and extent of the services they received (proposed RSA standard)
13. Percent of individuals who have achieved an employment outcome and who are satisfied with the employment they obtained as a result of their VR services (proposed RSA standard)
14. Other Indicators defined through cooperative planning with WVDRS

Subcategory Key Output Indicators for SD Cases are:

1. Rehabilitations of SD cases per 100,000 population
2. Rehabilitation rate for SD cases
3. Percent of SD closures with an employment outcome (proposed RSA standard)
4. Percent of employment outcomes for SD in a competitive setting (proposed RSA standard)
5. Percent of individuals with severe disabilities who are placed in competitive employment who have medical insurance available to them through their employment (proposed RSA standard)
6. Average cost per SD case
7. Average gain in earnings for SD cases
8. Average gain in percent with earnings for SD cases
9. Weekly earnings at closure for those individuals with severe disabilities who have achieved a competitive employment outcome (proposed RSA standard)
10. Other Indicators defined through cooperative planning with WVDRS

Contributing Factors (which will be empirically validated) include:

Client Characteristics
1. Age
2. Education
3. Severity of disability
4. Marital status
5. Work status at application
6. Sources of referral
7. Other client characteristics identified by WVDRS

Service Characteristics

1. Types of services received
2. Average time spent in rehabilitation process (at various statuses)
3. Average dollars spent for rehabilitation
4. Other service characteristics proposed by WVDRS

Economic Environment Characteristics

1. Unemployment rate
2. Ratio of employment to population
3. Ratio of civilian labor force to population
4. Per capita income
5. Other economic environment characteristics suggested by WVDRS

The project will develop a performance profile of WVDRS, the seven districts, and other appropriate program components using the 1994-95 fiscal year data. Additionally, a performance profile for each of the key subgroups of WVDRS cases such as SD/NSD, workers' compensation, SSDI, and head injury cases will be developed. If desired, comparisons with the 1993-94 fiscal year data will be made.

The project will develop a PE Report including the findings and conclusions of the study. Deliverables will include:

1. Performance Profile for WVDRS
2. Performance Profiles for each of the seven Districts
3. Performance Profiles for each desired program or subset
4. Interpretations, Conclusions, and Recommendations
5. Technical Appendix detailing variables and analyses.

TASKS

1. Organize a Project Management Team with Members from WVDRS and WVRRTC.

   a. Select members from WVDRS.
   b. Select members from WVRRTC.
   c. Set up meeting schedule.

2. Develop the Database from WVDRS Program Sources.

   a. Identify the data elements related to input, process, and output variables.
   b. Select the appropriate items related to Key Output Indicators and Contributing Factors to be included in the model.
   c. Coordinate with WVDRS data processing unit to develop the database.
   d. Develop the procedure for telecomputing with SAS protocol.

3. Collect Data.

   a. Configure WVDRS computer system to send appropriate 1994-95 data to WVRRTC.
   b. Configure WVRRTC computer system to receive 1994-95 data from WVDRS.

4. Analyze Data.

   a. Prepare the dataset to conform to the Key Output Indicator Model.
   b. Perform statistical analyses (correlational, factor, and regression) to establish empirical relationships between the KOIs and Contributing Factors on the HP9000 SAS platform.
   c. Run statistical analyses (including descriptive, univariate, and multivariate) on the selected KOI model(s).
   d. Generate numeric and graphic analyses of the program data.

5. Construct Preliminary Report.

   a. Prepare draft report.
   b. Circulate among the team members for review and feedback.

6. Prepare Final Report.

   a. Receive comments and suggestions from Project Management Team members.
   b. Incorporate the feedback to improve and finalize the report.
   c. Print the Final Report.
   d. Submit the Final Report including all deliverables.

BENEFITS

There are three distinct benefits to be derived from the conduct of this program evaluation. First, an in-depth picture of causes and effects in the WVDRS program will be provided. Such a picture of the key outcomes and the contributing factors has heretofore been unavailable to WVDRS. Hundreds of relationships at the district, state, and county levels will be brought to light, anyone of which might contribute to a better understanding of what causes a program or aspects of a program to flourish or fail in the face of difficult odds. Second, the relationships will be distilled to provide the essence of program performance. A Program Performance Profile will be provided for each district and for the overall state. These profiles represent a third level of reduction (1. raw data to 2. cause-effect relationships to 3. profiles of performance) that satisfy the primary requirements of program and standards evaluation as well as allow interpretations that go far beyond basic requirements. Third, the program evaluation will provide a solid platform from which to plan for future program development. Practical as well as theoretical implications will spark the planning process. The findings and recommendations will contribute to making the most of WVDRS's resources for the benefit of those they serve.

DIVISION OF REHABILITATION SERVICES
Post Office Box 50890, State Capitol
Charleston, West Virginia 25305-0890

DIRECTOR'S LETTER 96–12

December 28, 1995

Utilization of Community Resources

It is our Division's policy that community resources will be used to the maximum extent feasible to provide rehabilitation services in the most integrated settings possible, consistent with the principle of informed choice. Such community resources include, but are not limited to, community rehabilitation programs and public or other vocational or technical training programs.

As an example, our Division's strategy is to seek optimum utilization of the West Virginia Rehabilitation Center (WVRC) since, particularly regarding individuals with the most severe disabilities, WVRC is a uniquely valuable rehabilitation resource. Thus, Counselors should continue to consider WVRC when community resources for necessary rehabilitation services are either unavailable or inadequate. However, admission to WVRC generally should not be considered when adequate rehabilitation resources are available in the community and utilization of those resources is otherwise appropriate, consistent with the principle of informed choice.

This policy implements Sections 6.2(d) and 6.3(c) of our Interim State Plan for the State Vocational Rehabilitation Services Program, pursuant to Chapter 34, sections 361.22 and 361.56, of the current Code of Federal Regulations. See also Sections 361.31 and 361.33 of the proposed federal regulations for the State vocational rehabilitation services program which were announced by the Rehabilitation Services Administration on December 15, 1995.

Questions may be directed to either John Harrison, Assistant Director, Rehabilitation Services; William Tanzey, WVRC Administrator; or James Jones, Deputy Director, Operations.

William C. Dearien, Director

DIVISION OF REHABILITATION SERVICES
Post Office Box 50890, State Capitol
Charleston, West Virginia 25305-0890

DIRECTOR'S LETTER 96–11

December 12, 1995

1. FY97 MOR
2. Directions and Goals for our Field Program

1. FY97 MOR. As you know, our Division has been through significant changes during the past year. You also know that the pace of change is likely to increase over the next couple of years, both within our Division and in our external environment. We have met some challenges, but many more lie ahead, and surely some of those are as yet unforseen. However, we can see that overcoming our challenges will not be simple, easy, or safe.

> ***It should be plain to all that if we do not address our challenges boldly, work together, and learn together, then the public rehabilitation program will neither succeed nor survive.***

It looks like Congress will give us one more chance, but it could be our only one, and so, there can be no delay, no middle of the road. The time is now, and I invite you to move forward with us.

Boldness means making a common commitment to our mission, sharing a dynamic vision for our future, undertaking strategies to deliberately shape that future, setting clear goals, and then developing realistic plans for achieving those goals.

Working together means focusing on our customers and improving the efficiency and effectiveness of everything we do.

Learning together means understanding both the changes we are experiencing and the changes we have to make. Even more importantly, it means understanding the nature and processes of change itself. That is why our continuous quality improvement initiative is so crucial, and why your wholehearted participation in that profoundly challenging endeavor is so encouraging. If you can change, and I can change, then we all can change. But, we must first learn to change, and we must learn together.

Change we must. And change we shall. It is my job to give direction to that change and to help make it happen. To that end, I urge you to review our Division's statement of vision, mission, values, and strategies (attached). Along with similar statements to be developed for the Rehabilitation Services Field Program, the West Virginia Rehabilitation Center, and our Disability Determination Section, these will provide strategic direction for setting our goals.

The mid-year review for our FY96 Management by Objectives and Results (MOR) is scheduled for January 3–5, 1996. Following that review, I am asking both Deputy Directors and the Assistant Directors to submit written reports of progress by January 12, 1996, regarding their FY96 MOR.

By March 1, 1996, I am asking that they provide recommendations for FY97 MOR goals and objectives explicitly addressing each of our Division's strategies and the strategies for their respective program areas.

The development of those recommendations should include opportunities for participation by the involved employees and, to the greatest extent practical, representatives of our constituencies. Upon my approval, these strategies, goals, and objectives will become the foundation for developing our FY97 MOR.

Thus, our FY97 MOR will be responsive to our strategies, and it will structured around our strategic goals rather than simply reporting the diverse activities of our various programs and units, as in the past. This will, I believe, be a fundamental improvement in our approach to deciding what we must do and planning to get it done.

2. Directions and Goals for our Field Program. In this Director' Letter, I want to discuss some of my goals for our Division's field program. Of course, our field program's strategies for FY97 will include some initiatives already underway, along with several new ones. However, I expect that our work during the remainder of FY96 and our strategic planning for FY97 will encompass the following general directions and goals:

- **Focus on Employment Outcomes.** Our primary business is enabling persons with disabilities to prepare for, obtain, and retain competitive employment. That is Job One. Whatever contributes to doing that job should have priority. Anything that doesn't, shouldn't. Our job placement initiative is a beginning, as is our commitment to draw clear distinctions between independent living rehabilitation and vocational rehabilitation. But there is more to do, and we must set about doing it.

  Consistent with that resolve, I am asking that we commit to achieving a 15 percent increase in the number of rehabilitants who are placed into competitive employment, up from 1,923 for FY95 to a total of 2,211.

- **Counselor Empowerment.** We will identify, clarify, and strengthen the role of the Counselor in our programming. All of us have a contribution to make, but the Counselor is the backbone of our Division. We might have forgotten that, but we're going to remember.

  We are going to relieve both the Counselor and the Counselor's Secretary of unnecessary policies or inefficient procedures, give them the authority needed to discharge their responsibilities, and improve the information technology dedicated to their use.

Regarding information technology, over the next three years, we are going to improve the tools and technologies available to Counselors and their Secretaries by implementing a wide-area network (WAN) and a computer-assisted job matching system; providing each counselor a computer connected to the WAN; developing or procuring a system for case management that integrates with all relevant information systems; and dramatically improving our capabilities for collecting, analyzing, reporting, and using management information.

- **Building Partnerships and Alliances.** Our environment has become much more complex, and so has our work. More and more, creating new opportunities for success in serving our clients will depend on our successes in building effective partnerships and strategic alliances.

  Most especially, we need to reinvent our partnerships with employers and with community rehabilitation programs.

We need to revisit and renew our existing partnerships, and we need establish new ones. If we are going to develop an integrated network for comprehensive rehabilitation service delivery and job placement, we must learn, practice, and teach the skills of partnership, but it can't be just another goal for managers. It must become an integral and ordinary part of everyone's everyday work. From Counselor to Director, it must permeate our relationships with and within each community.

- **Informed Client Choice.** We are not here to build our dreams. We are here to help our clients build their dreams. It is the client's life, not ours. So, the choices must be the client's, not ours. Looking at it any other way is not just dumb, it's wrong.

  We need to strengthen our skills in understanding the client's aspirations, in gathering and communicating information the client needs to make choices, and in supporting the client's decisions, including our skill in finding other resources when the client needs help that we just cannot give.

Our role is to help the client find and understand the information necessary to make choices well, including information about what we can and cannot do to help the client act on those choices. By extension, this will require greater efforts to communicate our mission, vision, and strategies to our constituencies, and more effective, ongoing involvement of consumers in developing our strategic goals.

- **Cost-effectiveness and Efficiency.** Productivity in our mission performance should be a key subject of our continuous quality improvement efforts. Obviously, we cannot do substantially more of what we're doing the way we're doing it without substantially more resources. Just as obviously, we cannot be at all complacent about the results our clients have been getting, and wringing our hands and whining won't make it better. We have only so many staff. We have only so much money. And, in the end, we simply must make better use of both by reducing the resources we use to produce failure and converting those resources to success.

  Therefore, primarily through improving the quality of our services and the efficiency of our service delivery systems, I am asking that we reduce the total number of status 28 and 30 closures by 25 percent, from 2,128 for FY95 to less than 1,600.

  If we can do that, then I believe it becomes reasonable to pursue two related goals as well: first, an 8 percent increase in total rehabilitations, up to 3,168, compared to 2,934 for FY95; and second, a 24 percent increase in rehabilitations of persons with severe disabilities, from 1,661 in FY95 to 2,060.

I can't give you much more money or any more staff. We desperately need both, and if I could get more for you, believe me, I would. We're just not going to be able to get all the resources we need. But, we can learn to make better use of what we have.

In the absence of more resources, we have to change what we're doing in ways that enable more of our clients to be more successful, and, together, we're going to learn how to do that. Increasing the proportion of our resources that we use to produce success will require every bit of energy and ingenuity we can muster. The prospects for real innovation are exciting. But the work is enormous, and we don't have an idea to waste.

We have several teams working now to review the recommendations resulting from our participation in the Aspen Project. Those teams and/or other employees also will make other recommendations for other improvements, and we will pursue those in their turn. But, in this instance, there is no substitute for directly involving the people who do the work on the front lines.

> ***I hope that each District Manager will personally lead at least one quality improvement work team to explore the reasons why status 28 and 30 closures occur, to develop new approaches to helping more of these clients achieve success, to integrate those improved practices throughout the district, and to share that knowledge with other districts.***

We can't be afraid to take reasonable risks, particularly if we're going to serve persons with the most severe disabilities, so, we won't focus so much on preventing failures. Rather, we will focus on learning how better to foster and facilitate success for everyone we serve.

- **Reallocation of Resources.** If our primary business is enabling persons with disabilities to prepare for, obtain, and retain employment, then we need to allocate the greatest possible share of our human and financial resources to doing that job. As examples, we will move to implement the recommendations of the Strategic Planning Task Force regarding the West Virginia Rehabilitation Center; we will reduce our expenditures for medical evaluation and physical restoration; and we will begin seriously studying our traditional services, such as college training, to optimize the overall efficiency and cost-effectiveness of our service delivery operations.

  We will increase our budget for purchased case services by at least five percent in FY97, primarily as a result of reallocations resulting from efficiencies.

- **Measuring Program Outcomes/Benefits.** I believe in planning. Particularly when it's important, I believe in having a clue about what you're going to do, why you're going to do it, who's going to do it, and whether you get it done. But, many things we said were important were somehow too unimportant to measure.

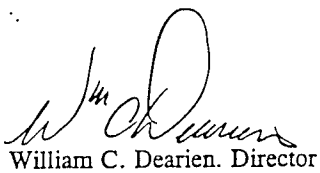
  You have to know what you've been getting before you can decide whether to keep doing what you've done.

Too often we haven't. That's why we are going to keep measuring some outcomes/benefits and why we are going to start measuring more. We will begin by targeting some currently-measured outcomes and reporting our progress to all employees monthly.

The attached report on employment outcomes achieved by our rehabilitants is a start. I would welcome your suggestions for improving both our measurements of program outcomes/benefits and our methods for reporting targeted results in a simple, useable manner.

I hope that you will think about what I have said, and that you will share with me your ideas, concerns, and questions. I invite you to participate as a stakeholder in defining the future of our field program.

I am proud to be associated with the best, and I would value your thoughts on these important matters.



William C. Dearien. Director

WEST VIRGINIA DIVISION OF REHABILITATION SERVICES

VISION

The vision of the Division of Rehabilitation Services is to be a responsible, flexible, dynamic, service delivery system which is economically accountable, valued by customers, driven by continuous quality improvement, and recognized and understood by government and all citizens for its commitment to enhancing the quality of life for persons with disabilities.

MISSION

The mission of the Division of Rehabilitation Services is to enhance the complete community integration and participation of persons with disabilities through consumer-driven services that focus on independence, employment, self-reliance, and preservation of individual dignity.

VALUES

The Division of Rehabilitation Services values and strives to demonstrate the following principles in the administration and operation of its programs:

- Continuously seeking excellence, openness, and honesty in all facets of its relationships with internal and external customers.
- Respecting diversity.
- Creating supportive work environments which encourage creativity and innovation by fostering employee participation, growth, and empowerment through opportunities for education and involvement.
- Celebrating and rewarding the successes of individuals and teams.

Adopted March 16, 1995

WEST VIRGINIA DIVISION OF REHABILITATION SERVICES

STRATEGIES

The Division of Rehabilitation Services employs the following strategies in achieving its mission:

- Realistically assessing strengths and weaknesses through outcome-based program evaluation of success in meeting program objectives.

- Achieving effective resource utilization by expanding its concepts of service delivery and directing maximal resources to serving consumers.

- Promoting the utilization of technology to deliver services more effectively and to enhance employability and quality of life.

- Developing relationships with business, industry, and labor, and cooperating with public and private agencies, to build service networks and ensure maximum community integration of persons with disabilities.

- Maintaining partnerships with constituents by seeking shared vision and values; educating consumers and advocates on policy issues; and facilitating consumers' efforts to reach their personal goals.

- Continuously improving the quality, efficiency, and effectiveness of service delivery through teamwork processes which empower staff to remove obstacles to success, solve problems proactively, and facilitate the development of services which enhance its unique role.

- Collaborating with all stakeholders in developing its vision, mission, and values.

- Soliciting consumer input to collaborate in developing, implementing, and monitoring, measurable service delivery strategies that assure responsiveness to consumer-identified needs.

Adopted March 16, 1995

WEST VIRGINIA DIVISION OF REHABILITATION SERVICES
Program Evaluation and Reporting Unit
Rehabilitation Comparisons - FY 93/FY 96 To Date

	Year to Date As of 11-30-95	CHALLENGE GOALS	FY 1995	FY 1994	FY 1993
Statewide Totals					
Status 26's	1,047	3,168	2934	2824	2867
Status 26's SD	634	2,060	1661	1591	1511
Status 26's Competitive Employment	641	2,211	1923	1828	1802
Status 26's SD Competitive Employment	302	--	861	829	712
Status 26's Supported Employment	21	100	89	65	49
Status 26's Competitive Employment Job Retention	220	646	646	654	Not Available
Status 26's Competitive Employment Substantial Gainful Activity	555	--	1613	1505	1495
Status 26's SD Competitive Employment Substantial Gainful Activity	246	--	667	639	546

WEST VIRGINIA DIVISION OF REHABILITATION SERVICES
Program Evaluation and Reporting Unit
Rehabilitation Comparisons - FY 93/FY 96 To Date

	Year to Date As of 11-30-95	CHALLENGE GOALS	FY 1995	FY 1994	FY 1993
District I Totals					
Status 26's	161		508	511	481
Status 26's SD	98		305	299	281
Status 26's Competitive Employment	97		314	320	289
Status 26's SD Competitive Employment	46		148	153	131
Status 26's Supported Employment	3		17	12	4
Status 26's Competitive Employment Job Retention	35		114	130	Not Available
Status 26's Competitive Employment Substantial Gainful Activity	83		249	269	239
Status 26's SD Competitive Employment Substantial Gainful Activity	35		103	116	98

WEST VIRGINIA DIVISION OF REHABILITATION SERVICES
Program Evaluation and Reporting Unit
Rehabilitation Comparisons - FY 93/FY 96 To Date

	Year to Date As of 11-30-95	CHALLENGE GOALS	FY 1995	FY 1994	FY 1993
District II Totals					
Status 26's	154		460	426	496
Status 26's SD	87		235	223	252
Status 26's Competitive Employment	86		265	273	297
Status 26's SD Competitive Employment	34		89	110	119
Status 26's Supported Employment	3		4	8	10
Status 26's Competitive Employment Job Retention	38		107	112	Not Available
Status 26's Competitive Employment Substantial Gainful Activity	72		231	237	252
Status 26's SD Competitive Employment Substantial Gainful Activity	24		76	89	92

WEST VIRGINIA DIVISION OF REHABILITATION SERVICES
Program Evaluation and Reporting Unit
Rehabilitation Comparisons - FY 93/FY 96 To Date

	Year to Date As of 11-30-95	CHALLENGE GOALS	FY 1995	FY 1994	FY 1993
District III Totals					
Status 26's	126		486	464	486
Status 26's SD	69		261	269	233
Status 26's Competitive Employment	97		359	341	330
Status 26's SD Competitive Employment	47		160	170	117
Status 26's Supported Employment	3		26	20	11
Status 26's Competitive Employment Job Retention	28		119	109	Not Available
Status 26's Competitive Employment Substantial Gainful Activity	85		302	272	273
Status 26's SD Competitive Employment Substantial Gainful Activity	40		119	127	86

WEST VIRGINIA DIVISION OF REHABILITATION SERVICES
Program Evaluation and Reporting Unit
Rehabilitation Comparisons - FY 93/FY 96 To Date

	Year to Date As of 11-30-95	CHALLENGE GOALS	FY 1995	FY 1994	FY 1993
District IV Totals					
Status 26's	193		424	391	400
Status 26's SD	128		261	240	221
Status 26's Competitive Employment	124		278	258	252
Status 26's SD Competitive Employment	63		135	134	110
Status 26's Supported Employment	3		15	13	4
Status 26's Competitive Employment Job Retention	37		85	70	Not Available
Status 26's Competitive Employment Substantial Gainful Activity	111		239	214	211
Status 26's SD Competitive Employment Substantial Gainful Activity	52		110	107	85

WEST VIRGINIA DIVISION OF REHABILITATION SERVICES
Program Evaluation and Reporting Unit
Rehabilitation Comparisons - FY 93/FY 96 To Date

	Year to Date As of 11-30-95	CHALLENGE GOALS	FY 1995	FY 1994	FY 1993
District V Totals					
Status 26's	111		467	491	485
Status 26's SD	69		260	251	244
Status 26's Competitive Employment	74		335	342	332
Status 26's SD Competitive Employment	38		157	135	123
Status 26's Supported Employment	2		13	6	6
Status 26's Competitive Employment Job Retention	18		123	140	Not Available
Status 26's Competitive Employment Substantial Gainful Activity	68		272	274	272
Status 26's SD Competitive Employment Substantial Gainful Activity	35		120	102	102

WEST VIRGINIA DIVISION OF REHABILITATION SERVICES
Program Evaluation and Reporting Unit
Rehabilitation Comparisons - FY 93/FY 96 To Date

	Year to Date As of 11-30-95	CHALLENGE GOALS	FY 1995	FY 1994	FY 1993
District VI Totals					
Status 26's	123		263	226	207
Status 26's SD	79		156	126	105
Status 26's Competitive Employment	66		166	123	125
Status 26's SD Competitive Employment	33		74	48	43
Status 26's Supported Employment	2		3	2	10
Status 26's Competitive Employment Job Retention	25		50	34	Not Available
tatus 26's ompetitive Employment ubstantial Gainful Activity	57		144	95	100
tatus 26's SD ompetitive Employment ubstantial Gainful Activity	28		62	34	29

WEST VIRGINIA DIVISION OF REHABILITATION SERVICES
Program Evaluation and Reporting Unit
Rehabilitation Comparisons - FY 93/FY 96 To Date

	Year to Date As of 11-30-95	CHALLENGE GOALS	FY 1995	FY 1994	FY 1993
District VII Totals					
Status 26's	179		326	315	312
Status 26's SD	104		183	183	175
Status 26's Competitive Employment	97		206	171	177
Status 26's SD Competitive Employment	41		98	79	69
Status 26's Supported Employment	5		11	4	4
Status 26's Competitive Employment Job Retention	39		48	59	Not Available
Status 26's Competitive Employment Substantial Gainful Activity	79		176	144	148
Status 26's SD Competitive Employment Substantial Gainful Activity	32		77	64	54

STATE OF WEST VIRGINIA

PERFORMANCE AUDIT
OF THE

DIVISION OF REHABILITATION SERVICES

Rehabilitation Services Have a Positive Impact on Employment and Earnings of Individuals with Disabilities

Rehabilitation Center Inefficient Use of Resources

OFFICE OF LEGISLATIVE AUDITOR
Performance Evaluation & Research Division
Building 5, Room 751
State Capitol Complex

CHARLESTON, WEST VIRGINIA 25305
(304) 347-4890

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January, 1996