



COMMONWEALTH of VIRGINIA

DEBRA FERGUSON, Ph.D.
COMMISSIONER

DEPARTMENT OF
BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES

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DBHDS SB 627 Work Group

MEETING AGENDA

Wednesday, July 2, 2014

10:00 a.m. – 2:00 p.m.

House Room 3, State Capitol (Tunnel)
10th and Bank Street Entrance
Richmond, VA

10:00 a.m.	I. Welcome and Introductions	<i>Connie Cochran, Assistant Commissioner, Developmental Services</i>
10:15 a.m.	II. Purpose	<i>Pat Finnerty, Facilitator PWF Consulting</i>
10:20 a.m.	III. Materials	
10:30 a.m.	IV. Work Group Process with Example	
10:50 a.m.	V. Facilitated Work Session: Segment 1	<i>Members</i>
11: 45 a.m.	BREAK: Collect Lunch	
12:00 p.m.	VI. Facilitated Work Session: Segment 2	<i>Members</i>
1:30 p.m.	VII. Process Consideration	<i>Members</i>
1:50 p.m.	VIII. Next Meeting Date: August 4, 2014	<i>Connie Cochran</i>
2:00p.m.	IX. Adjournment	<i>Connie Cochran</i>

Public comments will be received via email sb627@dbhds.virginia.gov
or hard copy: SB627 Work Group, DBHDS, 1220 Bank Street, Room 1323, Richmond, VA 23219.

Staff Contact: Sara Maddox
Deputy Director of Legislative Affairs
(804) 887-7397, sara.maddox@dbhds.virginia.gov

Northern Virginia Training Center

FACT SHEET

Northern Virginia Training Center (NVTC)

- Northern Virginia Training Center is slated to close in 2015.
- The census has decreased 34% since 2010 with a current census of 108.
- The FY 2014 operating budget for NVTC is \$39,239,309.
- The FY 2013 average annual per person cost of individuals who are receiving is \$277,989.
- Since 2012, there have been 38 discharges from Northern Virginia Training Center into the community. 33 individuals were placed in group homes, 1 in sponsored residential placement, and 4 in community ICFs.

Northern (NVTC)	FY 2010	FY 2011	FY 2012	FY 2013	June 5, 2014	% Change 2010-present
Census	166	157	152	142	108	-35%
Budget	\$36,801,811	\$37,410,013	\$38,691,372	\$39,474,428	\$39,239,309	+7%

Facility Features

- Year founded/built: 1973
- Northern Virginia Training Center is located on 85.63 acres.
- There are 16 buildings located on the grounds
 - 5 Residential Buildings, 1 is vacant and one is used by CIP Team
 - 2 Trailers- Psychology Service and Human Resources
 - 1 Food Service
 - 1 Administration with Treatment Room/Infirmary/Dental Suite and 1 residential unit
 - 1 Training with 2 residential units
 - 1 Housekeeping/Rehabilitation Engineering Shop
 - 1 Maintenance
 - 1 gym./pool
 - 1 Vocational Services
 - 2 Outdoor Pavilion/Nature Trail
- Renovations since 2010
 - Administration Building received a new HVAC system = 2012
 - Central Treatment Room/Infirmary and Dental Suite received new equipment = 8/2/2012
 - The residential unit bathrooms (1, 3 & 4) were updated = 5/2/2012 through 6/28/2012
 - Food Services new freezer/chillers = 9/6/2006
 - Cooling Tower = 12/1/2012
 - New generators = 10/11/2012
 - To meet Life Safety Code requirements (LSC) renovations to entire Residential Buildings #3, 6, and 7, and limited residential areas of Buildings 4 and 1 = 5/2/2012 through 6/29/2012

Virginia's Services System for Individuals with Intellectual/Developmental Disabilities FACTSHEET

Region II

Community Services Overview

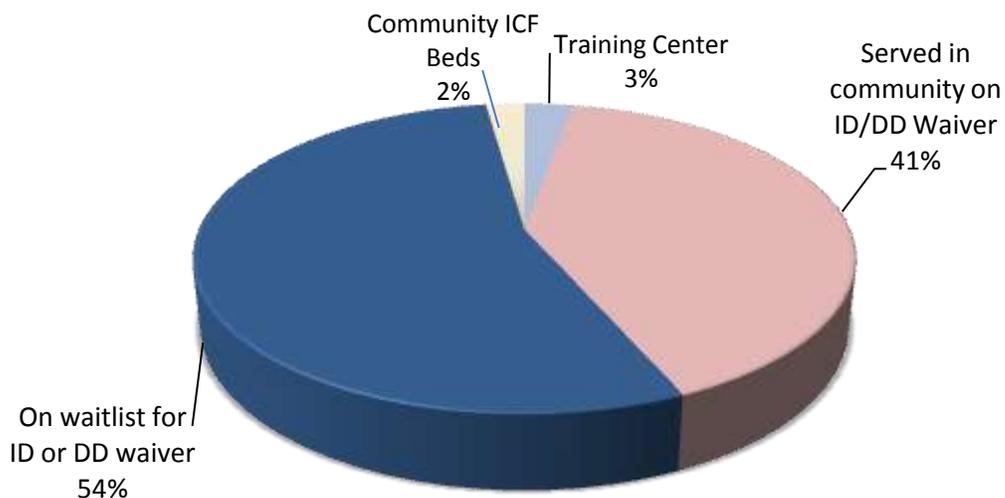
- Over the past several decades, advances in the community's ability to serve the needs of even the most severely disabled individuals has greatly reduced Virginia's reliance on large institutions in favor of more integrated services closer to individuals' homes and natural support networks.
- Virginia provides alternatives to institutional services through the use of the Medicaid Home and Community-Based Intellectual Disability (ID) Waiver, which enables individuals with intellectual disability to receive services while living in the community. Virginia's Developmental Disabilities (DD) Waiver serves individuals with developmental disabilities who do not have an intellectual disability diagnosis. It has identical services as the ID Waiver but does not provide congregate residential care such as group homes.
- Because of far lower infrastructure requirements and administrative support, the cost for community care is lower than in training centers. The FY 2013 average annual per person cost of individuals receiving services using the waiver in the community is \$66,339.

Average Statewide Expenses for ID/DD Waiver Programs

	FY 2010	FY 2011	FY 2012	FY 2013
ID Waiver	\$64,782	\$64,838	\$65,950	\$66,339
DD Waiver	\$30,003	\$31,401	\$28,155	\$29,919

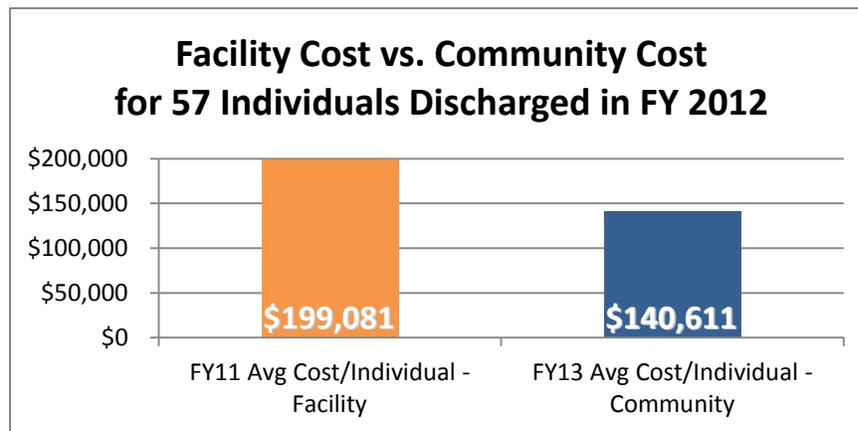
Region II

- Region II includes the following community services boards (CSBs): Alexandria CSB, Arlington County CSB, Fairfax-Falls Church CSB, Loudon County CSB, and Prince William County CSB.
- In Region II, 1,584 people are receiving services through an ID or a DD Waiver and the waiting list for waiver services in this region is now at 2,121 individuals, these numbers do not include individuals who receive local support due to ineligibility for waiver services.



Training Center Overview

- Since 1911, Virginia has run institutions, called “training centers,” to serve individuals with intellectual disability; Virginia currently operates five large training centers.
- In the early 1970s, there were over 5,000 people living in Virginia’s training centers. Because of expanded ability to serve individuals in communities closer to home, very few families chose training center care for their loved ones today, instead choosing waiver services in or closer to their homes. There is no waiting list for training centers and there were only four admissions in 2012.
- The statewide training center census has decreased 63 percent since 2000 and is 640 today (5/15/2014).
- Census decline has led to an increase in the training centers’ overall average per person cost. In FY 2011, the average annual cost was \$203,997 per person; in FY 2012 it was \$224,463; in FY 2013, it was \$262,245; in FY 2014 (YTD through April) it was \$263,530.
- The continued operation of residential services at current levels is fiscally impractical due to the significant and ongoing decline in population.



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- The census has decreased 35% since 2010 with a current census of 108.
- The operating budget for NVTC is \$39,239,309.
- The FY2013 average annual per person cost of individuals who are receiving is \$277,989.
- Since 2012, there have been 39 discharges from Northern Virginia Training Center into the community. 33 individuals chose group homes, 2 in sponsored residential placement, and 4 in community ICFs.

Northern (NVTC)	FY10	FY11	FY12	FY13	June 5, 2014	% Change 2010-present
Census	166	157	152	142	108	-35%
Budget	\$36,801,811	\$37,410,013	\$38,691,372	\$39,474,428	\$39,239,309	+7%

Southwest Virginia Training Center

FACT SHEET

Southwestern Virginia Training Center (SWVTC)

- Southwestern Virginia Training Center is slated to close on 2018
- The census has decreased 23% since 2010 with a current census of 148.
- The operating budget is \$27,177,128.
- The FY 2013 average annual per person cost of individuals who are receiving services in Southwest Virginia Training center is \$165,418.
- Since 2012, there have been 26 discharges from Southwestern Virginia Training Center into the community. 5 individuals were placed in group homes, 19 in sponsored residential homes, and 2 in family homes.

Southwestern (SWVTC)	FY10	FY11	FY12	FY13	June 5, 2014	% Change 2010-present
	192	182	174	163	148	-23%
Budget	\$25,071,006	\$25,530,695	\$26,927,380	\$26,963,212	\$27,177,128	+8%

Facility Features

- Year Founded/Built: 1973
- Southwestern Virginia Training Center is housed on a total of 94 acres.
- There are currently 22 buildings on the grounds of Southwestern Virginia Training Center
 - 16 residential
 - 2 administration/medical/dental/pharmacy
 - 1 gym
 - 1 habilitation/psychology/buildings and grounds
 - 1 food services/purchasing
 - 1 boiler/utility
- Renovations since 2005
 - All bathrooms installed with new floors
 - Parker tubs available on all units
 - New cabinets and updated appliances in kitchens
 - New medicine cabinets
 - New fire alarm system
 - New back-up generator for food service / purchasing building, new hood system, replacement equipment, retractable baskets
 - New shingle roofs approximately 8 years old
 - New gym floor three years old

Virginia's Services System for Individuals with Intellectual/Developmental Disabilities FACTSHEET

Region III

Community Services Overview

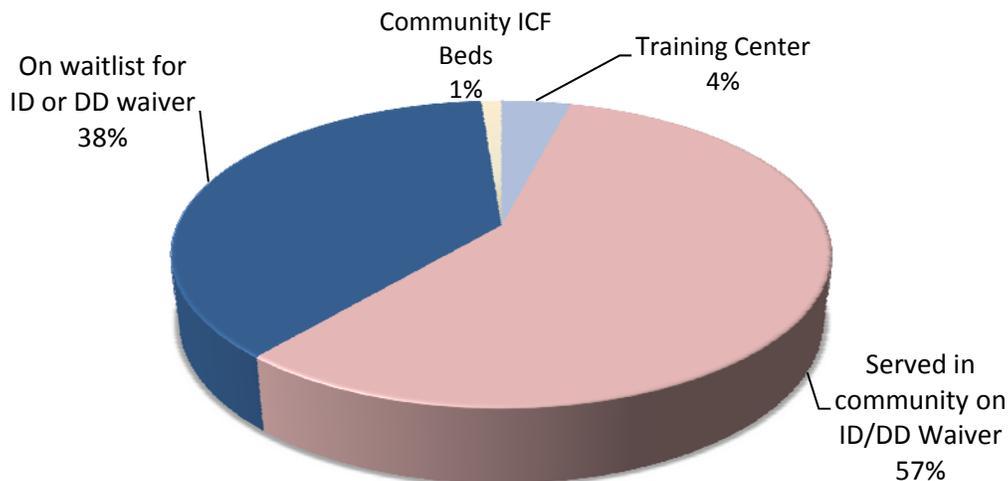
- Over the past several decades, advances in the community's ability to serve the needs of even the most severely disabled individuals has greatly reduced Virginia's reliance on large institutions in favor of more integrated services closer to individuals' homes and natural support networks.
- Virginia provides alternatives to institutional services through the use of the Medicaid Home and Community-Based Intellectual Disability (ID) Waiver, which enables individuals with intellectual disability to receive services while living in the community. Virginia's Developmental Disabilities (DD) Waiver serves individuals with developmental disabilities who do not have an intellectual disability diagnosis. It has identical services as the ID Waiver but does not provide congregate residential care such as group homes.
- Because of far lower infrastructure requirements and administrative support, the cost for community care is lower than in training centers. The FY 2013 average annual per person cost of individuals receiving services using the waiver in the community is \$66,339.

Average Statewide Expenses for ID/DD Waiver Programs

	FY 2010	FY 2011	FY 2012	FY 2013
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Region III

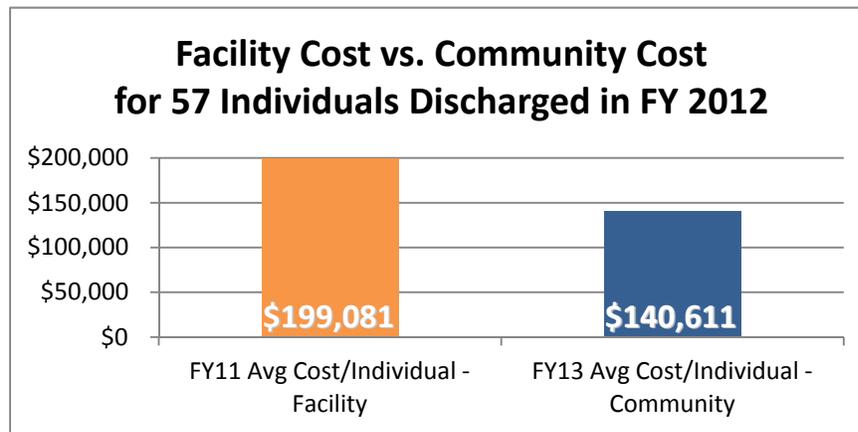
- Region III includes the following community services boards (CSBs): Alleghany Highlands CSB, Blue Ridge Behavioral Healthcare, Cumberland Mountain CSB, Danville-Pittsylvania CSB, Dickenson County Behavior Health Services, Highlands CSB, Mount Rogers CSB, New River Valley CSB, Piedmont CSB, and Planning District One Behavioral Health Services.
- In Region III, 2,083 people are receiving services through an ID or a DD Waiver and the waiting list for waiver services in this region is now at 1,370 individuals, these numbers do not include individuals who receive local support due to ineligibility for waiver services.



ID/DD Services Statewide Services

Training Center Overview

- Since 1911, Virginia has run institutions, called “training centers,” to serve individuals with intellectual disability; Virginia currently operates five large training centers.
- In the early 1970s, there were over 5,000 people living in Virginia’s training centers. Because of expanded ability to serve individuals in communities closer to home, very few families chose training center care for their loved ones today, instead choosing waiver services in or closer to their homes. There is no waiting list for training centers and there were only four admissions in 2012.
- The statewide training center census has decreased 63 percent since 2000 and is 640 today (5/15/2014).
- Census decline has led to an increase in the training centers’ overall average per person cost. In FY 2011, the average annual cost was \$203,997 per person; in FY 2012 it was \$224,463; in FY 2013, it was \$262,245; in FY 2014 (YTD through April) it was \$263,530.
- The continued operation of residential services at current levels is fiscally impractical due to the significant and ongoing decline in population.



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Central Virginia Training Center

FACT SHEET

Central Virginia Training Center (CVTC)

- Central Virginia Training Center is slated to close in 2020
- The census has decreased 32% since 2010 with a current census of 291. Of the 291 individuals being served at CVTC, 65 are receiving skilled nursing services
- The FY 2014 operating budget is \$81,437,544.
- The FY 2013 average annual per person cost of individuals who are receiving services is \$265,747.
- Since 2012, there have been 45 discharges from Central Virginia Training Center into the community: 27 individuals were placed in group homes, 6 in sponsored residential homes, and 2 in family homes.

Central (CVTC)	FY 2010	FY 2011	FY 2012	FY 2013	June 5, 2014	% Change 2010-present
Census	425	393	356	314	291	- 32%
Budget	\$81,817,025	\$83,473,838	\$81,297,621	\$83,444,508	\$81,437,544	-1%

Facility Features

- Year Founded /Built: 1911
- Central Virginia Training Center is housed on a total of 391 acres, of this acreage approximately 150 acres are in use.
- There are currently 75 buildings on the grounds of Central Virginia Training Center.
- 45 of the buildings are currently being used and 30 of the buildings are currently vacant.
 - Nursing Facility/SNF: 1
 - ICF Residential: 12
 - Day Activity/Programs: 6
 - Recreation/administration/support: 26
- Renovations since 1990 include
 - Building 31 (Nursing Facility) – Life Safety Code Renovations – 1997
 - ICF residential:
 1. Building 11: 2006
 2. Buildings 8 & 12: 2012
 3. Building 9: 2014
 4. Building 10: Under renovation – target date of completion Fall of 2015

Virginia's Services System for Individuals with Intellectual/Developmental Disabilities FACTSHEET

Region I

Community Services Overview

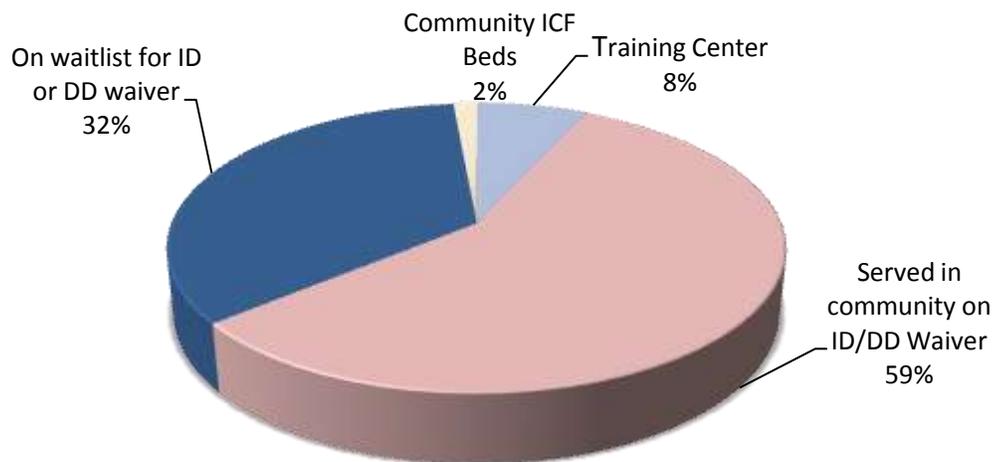
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- Because of far lower infrastructure requirements and administrative support, the cost for community care is lower than in training centers. The FY 2013 average annual per person cost of individuals receiving services using the waiver in the community is \$66,339.

Average Statewide Expenses for ID/DD Waiver Programs

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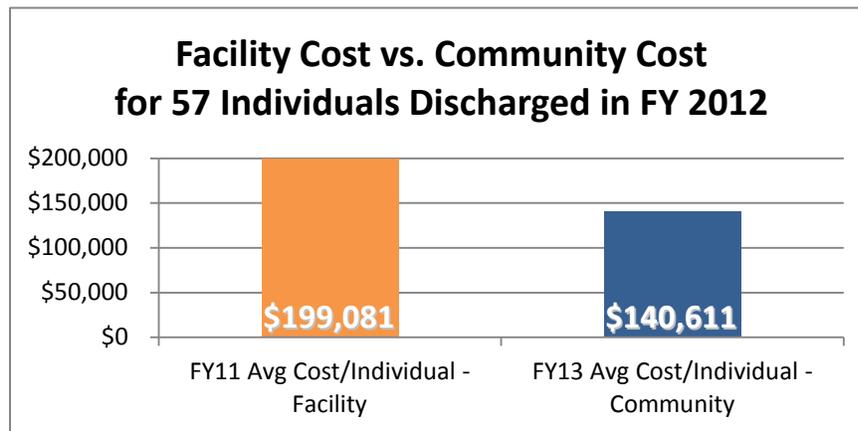
Region I

- Region I includes the following community services boards (CSBs): Harrisonburg-Rockingham, Horizon Behavioral Health, Northwestern CSB, Rappahannock Area CSB, Rappahannock-Rapidan CSB, Region Ten CSB, Rockbridge Area CSB, and Valley CSB.
- In Region I, 2,436 people are receiving services through an ID or a DD Waiver and the waiting list for waiver services in this region is now at 1,473 individuals, these numbers do not include individuals who receive local support due to ineligibility for waiver services.



Training Center Overview

- Since 1911, Virginia has run institutions, called “training centers,” to serve individuals with intellectual disability; Virginia currently operates five large training centers.
- In the early 1970s, there were over 5,000 people living in Virginia’s training centers. Because of expanded ability to serve individuals in communities closer to home, very few families chose training center care for their loved ones today, instead choosing waiver services in or closer to their homes. There is no waiting list for training centers and there were only four admissions in 2012.
- The statewide training center census has decreased 63 percent since 2000 and is 640 today (5/15/2014).
- Census decline has led to an increase in the training centers’ overall average per person cost. In FY 2011, the average annual cost was \$203,997 per person; in FY 2012 it was \$224,463; in FY 2013, it was \$262,245; in FY 2014 (YTD through April) it was \$263,530.
- The continued operation of residential services at current levels is fiscally impractical due to the significant and ongoing decline in population.



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- Central Virginia Training Center is slated to close in 2020.
- The census has decreased 32% since 2010 with a current census of 291. Of the 291 individuals being served at CVTC, 65 are receiving skilled nursing services
- The operating budget is \$81,437,544.
- The FY 2013 average annual per person cost of individuals who are receiving services is \$265,747.
- Since 2012, there have been 45 discharges from Central Virginia Training Center into the community: 27 individuals chose group homes, 6 in sponsored residential homes, 10 in community intermediate care facilities and 2 in family homes.

Central (CVTC)	FY10	FY11	FY12	FY13	June 5, 2014	% Change 2010-present
Census	425	393	356	314	291	- 32%
Budget	\$81,817,025	\$83,473,838	\$81,297,621	\$83,444,508	\$81,437,544	-1%

Southeastern Virginia Training Center

Fact Sheet

Southeastern Virginia Training Center (SEVTC)

- Southeastern Virginia Training Center is slated to remain open with an operational capacity of 75 beds.
- The census has decreased 48% since 2010 with a current census of 75.
- The FY 2014 operating budget is \$21,283,183.
- The FY 2013 average annual per person cost of individuals who are receiving service is \$257,491.
- Since 2012, there have been 24 discharges from Southeastern Virginia Training Center into the community. 9 individuals were placed in group homes, 23 in community ICFs, and 2 in nursing facilities.

Southeastern (SEVTC)	FY 2010	FY 2011	FY 2012	FY 2013	June 5, 2014	% Change 2010-present
	145	126	111	92	75	-48%
Budget	\$25,079,705	\$23,974,520	\$23,531,861	\$23,689,199	\$21,283,183	-15%

Facility Features

- Year Founded/Built: 1973
- Southeastern Virginia Training Center originally sat on approximately 96 acres. Currently the new homes and remaining administrative buildings sit on 21 acres.
- There are currently 17 buildings on the grounds that are being used and 3 buildings that the training center is using that are on the grounds that have been sold.
- Of the 20 buildings- 15 are new 5 bed homes for the residents. The remaining 5 buildings house administrative and additional program operations.
- Construction of the new homes began in 2010 and all homes have been occupied since 2013.
- Construction started on a new Administration/Operations building approximately 37,000 sq. ft. Staff and programs from three of the administrative buildings will be merged into the new building. Projected completion Spring 2015.

Virginia's Services System for Individuals with Intellectual/Developmental Disabilities FACTSHEET

Region V

Community Services Overview

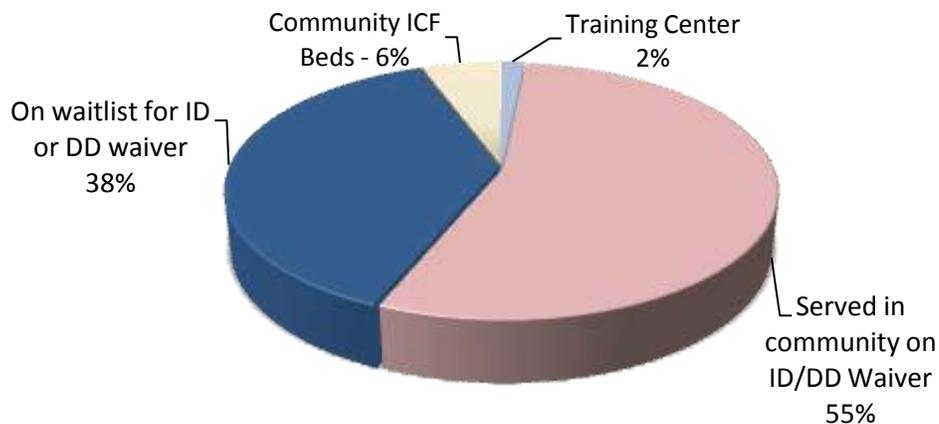
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- Because of far lower infrastructure requirements and administrative support, the cost for community care is lower than in training centers. The FY 2013 average annual per person cost of individuals receiving services using the waiver in the community is \$66,339.

Average Statewide Expenses for ID/DD Waiver Programs

	FY 2010	FY 2011	FY 2012	FY 2013
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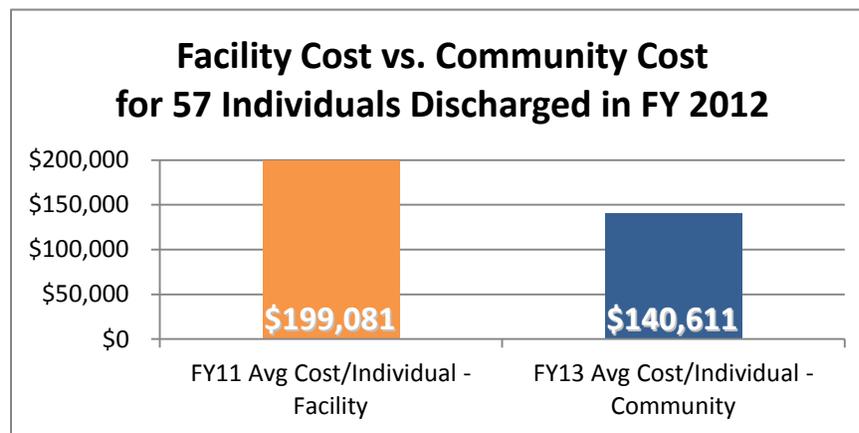
Region V

- Region V includes the following community services boards (CSBs): Chesapeake CSB, Colonial Behavioral Health, Eastern Shore CSB, Hampton-Newport News CSB, Middle Peninsula-Northern Neck CSB, Norfolk CSB, Portsmouth Department of Behavioral Healthcare Services, Virginia Beach Department of Human Services, and Western Tidewater CSB.
- In Region V, 2,585 people are receiving services through an ID or a DD Waiver and the waiting list for waiver services in this region is now at 1,798 individuals, these numbers do not include individuals who receive local support due to ineligibility for waiver services.



Virginia Training Center Overview

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- In the early 1970s, there were over 5,000 people living in Virginia’s training centers. Because of expanded ability to serve individuals in communities closer to home, very few families chose training center care for their loved ones today, instead choosing waiver services in or closer to their homes. There is no waiting list for training centers and there were only four admissions in 2012.
- The statewide training center census has decreased 63 percent since 2000 and is 640 today (5/15/2014).
- Census decline has led to an increase in the training centers’ overall average per person cost. In FY 2011, the average annual cost was \$203,997 per person; in FY 2012 it was \$224,463; in FY 2013, it was \$262,245; in FY 2014 (YTD through April) it was \$263,530.
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- The operating budget is \$21,283,183.
- The FY 2013 average annual per person cost of individuals who are receiving service is \$257,491.
- Since 2012, there have been 27 discharges from Southeastern Virginia Training Center into the community. 6 individuals chose group homes, 19 sponsored residential, and 2 family homes.

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	145	126	111	92	75	-48%
Budget	\$25,079,705	\$23,974,520	\$23,531,861	\$23,689,199	\$21,283,183	-15%

Virginia's Services System for Individuals with Intellectual/Developmental Disabilities FACTSHEET

Region IV

Community Services Overview

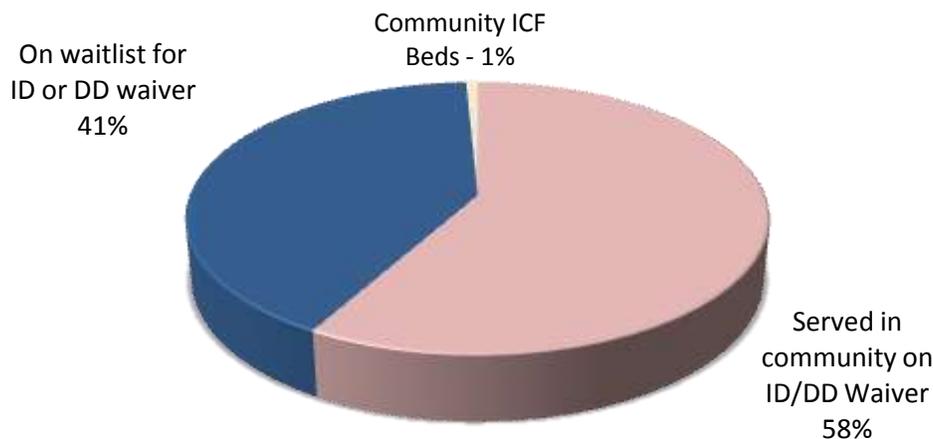
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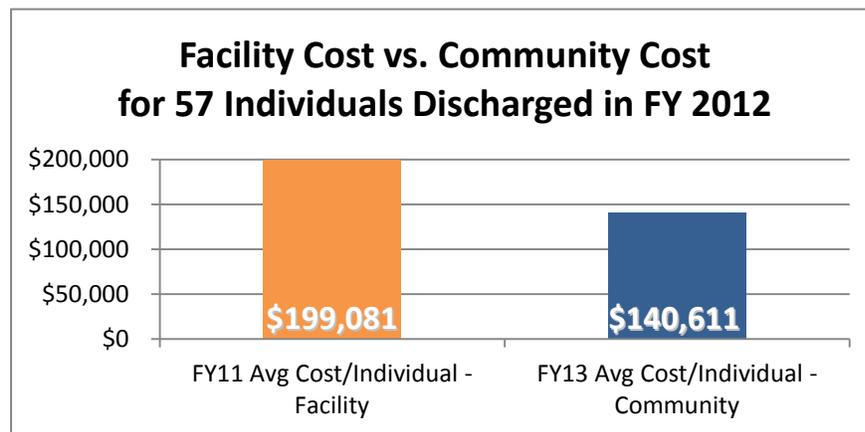
Region IV

- Region IV includes the following community services boards/behavioral health authority (CSBs): Chesterfield CSB, Crossroads CSB, District 19 CSB, Goochland Powhatan Mental Health, Hanover County CSB, Henrico CSB, Richmond Behavioral Health Authority, and Southside CSB.
- In Region IV, 2,440 people are receiving services through an ID or a DD Waiver and the waiting list for waiver services in this region is now at 1,725 individuals, these numbers do not include individuals who receive local support due to ineligibility for waiver services.



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- The continued operation of residential services at current levels is fiscally impractical due to the significant and ongoing decline in population.



Southside Virginia Training Center (SVTC)

- The last person moved from Southside Virginia Training Center on May 21, 2014.
- The facility is slated to close officially on June 30, 2014.

Central (SVTC)	June 2010	June 2011	June 2012	July 2013	May 21, 2014
Census	267	242	197	113	0

What is *Olmstead*?

- *Olmstead* is not a law but a 1999 Supreme Court decision (*Olmstead v. L.C.*).
 - The Supreme Court found that the segregation of persons with disabilities constitutes discrimination in violation of Title II of the Americans with Disabilities Act (ADA).
- Compliance requires that individuals with disabilities receive services in the most integrated setting appropriate to their needs.
- Applies to publicly funded services.

Importance of *Olmstead*

Virginians with disabilities have a right to enjoy the same benefits of society and freedoms of everyday life that Virginians without disabilities enjoy. The Commonwealth has an obligation under the U.S. Supreme Court's Olmstead v. L.C. decision, the Americans with Disabilities Act, and the Virginians with Disabilities Act to provide appropriate opportunities for people with disabilities to become fully integrated into the community if they choose to do so.

Executive Directive 6 (2007)

***Olmstead* in Virginia**

- After the Supreme Court decision Governor Warner convened the *Olmstead* Task Force.
- The Community Integration Advisory Commission now makes recommendations to the Governor and monitors the State's progress towards compliance.
- The Community Integration Implementation Team, in consultation with the Commission, is responsible for writing and annually updating the Commonwealth's *Olmstead* Strategic Plan.
- Comprehensive, effectively working *Olmstead* plans are one component of compliance with the decision.
- Virginia's *Olmstead* Strategic Plan: <http://www.olmsteadva.com/>

Virginia's Settlement Agreement with the U.S. Department of Justice Background and Status

As of June 5, 2014

Background

In August 2008, DOJ initiated an investigation of Central Virginia Training Center (CVTC) pursuant to the Civil Rights of Institutionalized Persons Act (CRIPA). In April 2010, DOJ notified the Commonwealth that it was expanding its investigation to focus on Virginia's compliance with the Americans with Disabilities Act (ADA) and the U.S. Supreme Court Olmstead ruling. The Olmstead decision requires that individuals be served in the most integrated settings appropriate to meet their needs consistent with their choice. In February 2011, DOJ submitted a findings letter, concluding that the Commonwealth fails to provide services to individuals with intellectual and developmental disabilities in the most integrated setting appropriate to their needs.

In March 2011, upon advice and counsel from the Office of the Attorney General, Virginia entered into negotiations with DOJ in an effort to reach a settlement without subjecting the Commonwealth to an extremely costly and lengthy court battle with the federal government. On January 26, 2012, Virginia and DOJ reached a settlement agreement. The agreement resolves DOJ's investigation of Virginia's training centers and community programs and the Commonwealth's compliance with the ADA and Olmstead with respect to individuals with intellectual and developmental disabilities.

Primary Objective

To prevent the unnecessary institutionalization of individuals with ID/DD and to provide them opportunities to live in the most integrated settings appropriate to their needs consistent with their informed choice.

Target Population

Individuals with ID/DD who meet any of the following criteria:

- (1) Currently reside in a TC,
- (2) Meet the criteria for the wait list for the ID/DD waivers, or
- (3) Currently reside in a nursing home or ICF.

Agreement Stipulations

- **ID/DD Waiver Slots:** Creation of 4,170 slots for target population by June 30, 2021.
 - 805 waiver slots will enable individuals in training centers to transition to the community.
 - 2,915 waiver slots for individuals with ID on the urgent waitlist to transition to the community; or for individuals with ID under 22 years of age to transition from ICFs and nursing facilities.
 - 450 waiver slots for individuals with DD on the waitlist to transition to the community or for individuals with DD under 22 years of age to transition from ICFs and nursing facilities.
- **Individual and Family Support Program (IFSP):** Creation of IFSP to support 700 individuals in FY13 & 1,000 individuals each year FY 2014 – FY 2021. This program will ensure that families who are assisting family members with ID/DD who live independently have access to person-centered and family-centered resources.

- **Statewide crisis system for individuals with ID/DD:** Must include: (1) crisis point of entry, (2) mobile crisis teams, and (3) crisis stabilization programs.
- **Other Requirements:** *(not comprehensive)*
 - Ensure that individuals receiving HCBS waiver services receive case management;
 - Provide target population with integrated day opportunities, including supported employment;
 - Increase access to independent living options to include rental assistance;
 - Provide oversight to CSBs/providers & require providers to implement a risk management and quality improvement program;
 - Implement discharge and transition planning processes at all training centers; and,
 - Regularly conduct unannounced licensing inspections of providers serving individuals.
 - Implement a real time web-based incident reporting system and protocol for use by all Training Centers, CSBs/providers.
 - Undertake Quality Service Reviews to ensure the adequacy of providers' quality improvement strategies.

Training Center Census and Projected Closure Date

Training Center	As of December FY12	As of May 29 nd FY14	Projected Closure Date
SVTC (Petersburg)	226	0	FY 2014 – June 30 th
NVTC (Fairfax)	152	108	FY 2015 – June 30 th
SWVTC (Hillsville)	170	148	FY 2018 – June 30 th
CVTC (Lynchburg)	359	291	FY 2020 – June 30 th
SEVTC (Chesapeake)	110	75	Remains open at 75 beds
Total	1,017	622	

Summary of the 10-Year DOJ Settlement Agreement

	Base Projections	Current Projections
Total Cost¹	\$2.4 Billion	\$2.5 Billion
GF Share of the Cost	\$1.2 Billion	\$1.2 Billion
GF savings and offsets²	\$ 826.9 Million	\$806.0 Million
New GF required³	\$ 380.7 Million	\$439.0 Million

¹ Includes total state and federal costs to implement the DOJ settlement include ID/DD waivers, crisis management, family support, facility transition waivers, administration, monitoring, quality management systems, and facility closure costs.

² Includes facility savings appropriations that were in place in FY 2012 before the Trust Fund was established (base funding) and \$60 million in Trust Funds that were provided in fiscal years 2012 and 2013.

³ Base projections reflect actions by 2013 session of the General Assembly which added \$30.4 million in adult crisis funds and \$10 million in children's crisis funding over nine years.

Outstanding Issues *(not comprehensive)*

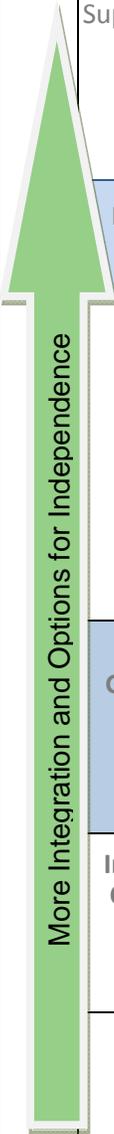
- Barriers to closing NVTC and budgeted savings tied to closure;
- Understanding the impacts associated with moving individuals from training center to training center versus training center to community;
- Consequences of Senate Bill 627 (Newman Bill); and,
- Seamless transition from bridge funding to new comprehensive waiver (potential FY16 funding gap).

FAQs

Frequently Asked Questions About Training Center Closures

1. What are placement options in the community and can individuals continue to reside in a training center?
2. What is the discharge process?
3. How will DBHDS develop community capacity to support individuals leaving training centers and for individuals on the waiting list for Medicaid waivers?
4. How does DBHDS ensure the quality of community providers?

1. *What are placement options in the community and can individuals choose to continue to reside in a training center?*



Setting	Description
Supported Living	The provision of community support services and other structured services to assist individuals, to strengthen individual skills, and provide environmental supports necessary to attain and sustain independent community residential living. Services include drop-in or friendly-visitor support and counseling to more intensive support, monitoring, training, in-home support, respite care, and family support services. Services are based on the needs of the individual and include training and assistance. These services normally do not involve overnight care by the provider; however, due to the flexible nature of these services, overnight care may be provided on an occasional basis.
Family Home	When consistent with their needs and informed choice, individuals may live with the proper supports in their own family homes or even in their own apartments. This option includes an agreement with the individual, authorized representative, and case manager on the types of supports that are needed for the individual to live there successfully.
Sponsored Residential Services	Sponsored residential services are supports provided in a person's or family's ("sponsor's") home. The sponsor is evaluated, trained, supported and supervised by a provider agency that is licensed by DBHDS. Only one or two individuals may receive sponsored residential services in one home. Sponsor homes must meet the requirements of the State Licensing Regulations. The physical environment, design, structure, furnishing, and lighting of the home must be safe and appropriate. The provider agency must conduct an assessment to identify physical, medical, behavioral, and functional preferences and needs of each individual it serves through a sponsor home. This information is used to create an individualized services plan that must be implemented to provide the medical, behavioral, and other supports required for the individual's success in the community. Both the provider agency and the sponsor home must comply with State Licensing and Human Rights Regulations.
Group Home Residential Services	Group home residential services provide 24-hour supervision in a community-based, home-like dwelling operated by a provider agency licensed by DBHDS. Group homes typically provide services to four to eight individuals. The provider agency requirements are essentially the same as those listed under sponsored residential services. The individuals must be provided the medical, nursing, and behavioral supports required to live successfully in the community. In contrast to sponsored residential services, the group home provider employs persons to work in the group home instead of contracting with sponsors to provide services in their own homes.
Intermediate Care Facility (ICF or ICF/IID)/	ICFs/IID is another example of residential services providing 24-hour supervision to individuals in a community-based, home-like dwelling operated by a provider agency. ICF/IIDs typically provide services to four to 12 individuals. An ICF/IID community home is different from a group home because it is not only licensed by DBHDS, but is also certified for Medicaid funding by the Virginia Department of Health. There are additional specific requirements for medical care and staffing. The ICF/IID provides or contracts directly for all the services the individual requires.
Nursing Facility	Health care facility for patients who require long-term nursing or rehabilitation services. Services provided in a nursing facility include nursing and related services, specialized rehabilitative services, medically-related social services, pharmaceutical services, dietary services, and professionally directed program of activities to meet the interests and needs for wellness.

Placement in another training center or a nursing facility are other options. These two options are not considered community placements in an integrated setting. Per the Settlement Agreement, DBHDS conducts a discharge process that is based on the assumption that, with sufficient supports and services, all individuals with complex needs can live in an integrated setting. In accordance with Virginia Code § 37.2-837(A)(3), if an authorized representative does not consent to discharge from a training center, the individual will not be moved to the community; however, if an individual and authorized representative choose to remain in a training center, the individual can be transferred to another training center, as determined by the Commissioner pursuant to Virginia Code § 37.2-840, when a training center closes. We encourage individuals and families to actively participate in the discharge process in order to understand the options available to them in the community.

Participation in the discharge process enables DBHDS to understand the barriers and essential support needs of individuals so that community capacity can be developed in the locality/region where the individual would like to reside. Without the active participation of the individual and authorized representative in the discharge process, it is difficult to understand at the regional and state level exactly what supports are required in our communities to serve individuals who currently reside in our training centers.

2. What is the discharge process?

In January 2012, the Commonwealth signed a 10-year settlement agreement with the US Department of Justice that agreed to improve Virginia's overall developmental disability system by providing more community-based services and supports for individuals, including those in training centers. As part of this agreement, DBHDS must conduct a consistent discharge process at each training center based on the premise that all individuals, with sufficient supports and services, can reside in the community. DBHDS is committed to ensuring that each individual residing at a training center is served in the most integrated setting that is available and appropriate to meet his or her needs in accordance with his or her choice.

To fulfill this commitment, DBHDS has implemented an improved discharge process to support consistent discharge planning activities that will ensure individual choice and safety, including:

- Developing a discharge plan before an individual moves that addresses the individual's developmental, behavioral, social, health, and nutritional status, and personal preferences;
- Providing reasonable time to plan for and prepare the individual and family/AR for discharge;
- Ensuring that all essential support needs will be met in the community;
- Providing a post-move plan that will assist the individual in adjusting successfully to his or her new home; and
- Providing post-move monitoring to ensure the continuation of supports and services as identified in the pre- and post-move process.

The discharge process will help families understand the living options that are currently available or can be established and make the choice that is best for the individual's successful move to the community. It has been our experience with the individuals who have already successfully moved from training centers that once an individual actively begins the discharge process, which begins on the date of the initial pre-move planning meeting, the process takes approximately 12 weeks to complete.

3. How will DBHDS develop community capacity to support individuals leaving the training centers and for individuals on the waiting list for Medicaid waivers?

DBHDS and the Department of Medical Assistance Services (DMAS) are taking the following action steps to develop these supports:

- DBHDS and DMAS have worked together to ensure that we are maximizing coverage under the current waiver program for behavioral supports and 24 hour nursing. Examples include:
 - Nursing services for extensive medical supports on a 24/7 basis
 - Nursing services at employment or day support programs
- DBHDS is providing Bridge Funding to support individuals moving from SVTC and NVTC. Examples of Bridge Funding include:
 - BCBA and ABA supports directly with an individual;
 - Home modification, DME, and assistive technology for individuals moving to group homes (current waiver only provides this for individuals moving to their own home);
 - Nutritional supplements currently not covered by DME provisions in the existing Medicaid program;
 - Specialized intensive training for community provider staff on individualized medical and behavioral issues and needs prior to an individual's transition;
 - Room and board supplements; and
 - Behavioral supports during day support or employment activities.
- DBHDS and DMAS have obtained approval from CMS of the 25 percent exceptional rates for congregate residential services, and this is working through the regulatory process.
- DBHDS and DMAS are partnering with Human Services Research Institute (HSRI) to study how to modify the current ID waiver, as well as other waivers supporting individuals with developmental disabilities. The *My Life, My Community* study will recommend changes to better support individuals with the most complex medical and behavioral needs in communities. The study is focused on ensuring there are adequate services and supports for individuals moving from training centers to the community. The earliest date recommendations will be implemented is FY 2016. DBHDS intends to use bridge funding to support individuals until these waiver changes occur.
- DBHDS is working to close on the sale of some of its facility properties so funds can be deposited into a revolving trust fund to be used to develop community capacity to support individuals moving from training centers (Item 314. C. of the 2013 *Appropriation Act*). The recent sale of surplus property at the Southeastern Virginia Training Center (SEVTC) in Chesapeake is one example.

4. How does DBHDS ensure the quality of community providers?

DBHDS has almost doubled the number of licensing specialists they have on the ground. The following other steps have been taken to improve oversight and enforcement:

- The Settlement Agreement requires case managers to provide enhanced oversight of individuals who meet certain high risk criteria, including individuals who have lived in training centers and moved to the community. In addition, we have put in place rigorous post move monitoring process with visits from licensing, training center staff, human rights, and the CSB within the first days, weeks, and months after an individual moves to the community to ensure his or her health and safety;
- Under the Settlement Agreement, licensing is also required to conduct additional visits to individuals at risk and has been conducting these visits since March 2013; and
- DBHDS is monitoring and collecting data concerning individuals in the Settlement Agreement target population using a web-based reporting system. The system has been in operation since April 2013. It is an enhancement of the same system used for years at training centers and other DBHDS facilities. This system has enabled DBHDS licensing specialists to go on site and investigate any problematic situations much more quickly than before.

Background and Current Status

At the beginning of FY2014, there were five training centers in the DBHDS system:

- Southside Virginia Training Center (SVTC), Petersburg
- Northern Virginia Training Center (NVTC), Fairfax
- Central Virginia Training Center (CVTC), Madison Heights
- Southeastern Virginia Training Center (SEVTC), Chesapeake
- Southwestern Virginia Training Center (SWVTC), Hillsville

SEVTC has been downsized to 75 beds. The campus is being reduced in size to accommodate the new census. It has fifteen (15) 5-bed homes and two program buildings on the site. A new support services building is being constructed on a contiguous site which will be leased by the facility on a long term basis.

NVTC has downsized to a census of approximately 100. It has closed two of its residential buildings: Buildings #5 and # 8. Residential Building #4, Building #6 and Building #7 have recently been renovated and remain in use. Building #1 has been renovated and contains administration, support services and residence for individuals with medical needs.

CVTC has downsized to a census of approximately 290. Four buildings have recently been renovated, specifically: Building #8, #9, #11, #12. Building #10 is currently being renovated and will be completed in April 2015. This portion of the campus is known as the Lower Rapidan and will have 120 beds which will be fully compliant with the building code, life safety code and conditions of participation for the Center for Medicare /Medicaid Services (CMS). Building #31 continues to be used by clients who have need of skilled nursing services and it has a capacity of approximately 80 beds. The remainder of individuals are housed on the first floors of several buildings in an area known as Bannister Hall comprised of Building #15, #16, #17 and #18. These buildings have not been renovated, and have recently had stand-by electrical power added. They do not meet modern building codes or new life safety requirements.

SWVTC has downsized to approximately 150 and is occupying and using all of its buildings.

SVTC has closed and all buildings are closed or have been transferred to Central State Hospital.

Since the announcement of the planned closure of these sites, no maintenance reserve funds been expended on these facilities. All repair and replacement has been with operation and maintenance funds available to the facilities. Since capital projects and maintenance reserve funds are from the proceeds of the sale of bonds, any investment in the property will have to be repaid to Virginia Department of Treasury, along with the expense of retiring the bonds when the property is sold, in order for Virginia to continue to meet federal regulations of the use of bond funds.

Future Use and Deferred Maintenance

If the current training centers remain open and operating for the foreseeable future, capital investment will be necessary to keep them code compliant and following the conditions of participation from CMS. Each facility has unique needs in this regard.

All of the DBHDS facilities were recently surveyed by VFA, Inc. for the Facility Index and Condition Assessment System (FICAS). This system projects the amount of money it will take to bring the facility up to modern codes and standards.

SWVTC has an estimated cost to update the facility is \$17,305,996. The largest portion would be directed at the homes (cottages) which have not been updated since their construction in 1975. The assessed value of the property is \$8,444,000 according to Carroll County records.

NVTC has an estimated cost of \$49,196,347 to update the facility. However, this includes buildings which have been abandoned and are not needed for continued use and the current population. When these buildings are removed from the equation, the estimated cost is reduced to \$40,832,968. NVTC has an assessed value in 2014 of \$24,001,000 according to Fairfax County records.

CVTC has an estimated cost of \$192,501,892 (from the Facility Index and Condition Assessment System (FICAS) and refers to the amount of money to be budgeted to correct current conditions to current standards and codes). However, a substantial portion of the campus has been abandoned and is not occupied. It is estimated that 66% of the campus is utilized in some fashion at this time. When the abandoned buildings are removed, the estimated cost is \$127,051,249. The assessed value is \$43,623,700 according to Amherst County records.

DOJ Settlement Agreement Planned Facility Savings

Training Center	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
	<i>Actual</i>	<i>Projected</i>	<i>Enrolled Budget Bill</i>		<i>Based on DOJ Model</i>				
CVTC	(\$1.6)	(\$1.6)	(\$5.9)	(\$10.9)	(\$16.2)	(\$22.2)	(\$27.6)	(\$31.6)	(\$34.5)
NVTC	\$0.0	(\$2.8)	(\$6.9)	(\$15.0)	(\$17.0)	(\$17.0)	(\$17.0)	(\$17.0)	(\$17.0)
SVTC	(\$4.0)	(\$9.8)	(\$25.8)	(\$25.9)	(\$25.9)	(\$25.9)	(\$25.9)	(\$25.9)	(\$25.9)
SEVTC	\$0.0	(\$0.8)	(\$4.0)	(\$4.7)	(\$4.7)	(\$4.7)	(\$4.7)	(\$4.7)	(\$4.7)
SWVTC	\$0.0	(\$1.3)	(\$1.9)	(\$3.4)	(\$5.8)	(\$8.8)	(\$11.2)	(\$11.7)	(\$11.7)
Total	(\$5.6)	(\$16.3)	(\$44.5)	(\$59.8)	(\$69.6)	(\$78.6)	(\$86.3)	(\$90.9)	(\$93.8)

Facility Savings are personnel and indirect (non personnel) savings associated with the closure of the training centers.

Some examples of non personnel savings are: power plant, food services, laundry, and housekeeping. In order to realize projected savings, the following assumptions must be upheld.

- Training centers close according to schedule;
- Discharges occur on schedule as forecasted;
- Staff layoffs occur as planned; and
- Indirect expenses continue to decrease as training center census decreases.

Each year training center budgets are reduced in order to reflect the savings achieved as census is reduced.



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Comment to be considered by the Members of the SB627 Workgroup:

We have reviewed the material distributed by DBHDS in anticipation of your first meeting on July 2, 2014 in the context of SB627 which charges the workgroup "to consider options for expanding the number of training centers that remain open, in whole or in part, in the Commonwealth" and which charges DBHDS with the responsibility of certification that "(i) the receiving training center or community-based option provides a quality of care that is comparable to that provided in the resident's current training center" in multiple modalities.

As providers of community services including supervised apartments, sponsored residential homes, group homes (both small and large) and community ICF-IIDs, Day Support, pre-vocational and Supported Employment (both individual and group) we are inclined to assert that we have the expertise and the skills to provide better than comparable care in more integrated settings. Organizations which are members of VNPP average more than 25 years in the business of providing community supports and serve more than 70,000 individuals in their many programs.

It is also notable that currently the private sector provides approximately 80% of the community residential service and more than 75% of the Day Support for the ID population (the details are attached).

However:

- The consistent funding strategy for the ID Waiver has been to increase the number of slots (97% increase since FY 2000) to respond to the critical needs of those still waiting for service;
- In the same period total payments have increased by more the 300%. The factors contributing to the increase in cost are the increase in slots and the increase in the number of individuals in residential services (a 100% increase since FY2000), the implementation of the Northern Virginia differential, and a modest (~18%) increase in rates* over the same period;
- In order to accommodate significant increases in overhead costs, the necessity of increasing wages and benefits to attract and retain qualified staff, the cost of compliance in a more robust regulatory environment, and the costs associated with care for a more challenging population, providers have become adept at managing very efficiently and in controlling their costs.

The ID Waiver is the most expensive of the Waivers which garners a lot of legislative scrutiny; ongoing efforts to contain costs may further endanger the provider community's ability to provide quality and comparable service.

Submitted on June 27, 2014

* ROS rates for Residential Services

ID Residential

Supervised Living, Group Homes & ICF-IIDs

	CSB	Private	Total	% Private
ID Residential Sites	277	1,062	1,339	79.3%
ID Residential Capacity	1,483	5,444	6,927	78.6%
ICF-IID Sites	34	24	58	41.4%
ICF- IID Capacity	225	253	478	52.9%
ID Group Home Sites	191	941	1,132	83.1%
Group Homes ≤ 4 beds	77	431	508	84.8%
Percentage of Total GH Sites	40%	46%	45%	
ID Group Home Capacity	1,037	4,709	5,746	82.0%
Supervised Living Sites	52	97	149	65.1%
Supervised Living Capacity	221	482	703	68.6%

Sponsored Residential

Sponsored Sites	184	1,142	1,326	86.1%
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Day Support Programs

Day Support Programs	68	230	298	77.2%
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Comments on DBHDS Materials Sent to SB627 Work Group

Submitted by Jane Powell

7/1/2014

Materials do not appear directly to address the stated purpose of the work group, explicitly worded in SB627 – the consideration of options to leave more training centers open. On the contrary, the bulk of the materials continue to advocate training center (TC) closures. The “Fact Sheet” contains opinions as well as facts. My comments on the specific documents provided are as follows:

1) Fact Sheets

- Average annual per person waiver cost of \$66,339 in 2013 is irrelevant, because TC people are not average but require the most intensive supports and services. The HCBS waiver does not cover all services required by TC people, a fact now recognized by all concerned. Moreover, waiver costs are capped, and TC costs are needs-based, with no limitations. Waiver costs for former TC people will increase with increased services, under current waiver redesign negotiations with CMS. Even prior to the approval and funding of a new waiver in 2016, months and years of DBHDS presentations addressing Settlement Agreement (SA) implementation have shown ever-increasing cost estimates for discharging TC residents.
- A 2006 waiver study by the University of Minnesota found that those who receive daily medical care are more costly to serve in the community than in institutions. Among those who do not receive daily medical care, adjusting for age, level of disability, level of ID, co-occurrence of mental illness or autism and other factors, ICF/ID costs were just 3% higher than waivers in 2006. CVTC people, on average, are the oldest, sickest and most disabled TC population, many of whom receive a high level of medical services on a daily basis. Only two individuals have fewer than two additional diagnoses on top of intellectual disability. They require intensive medical services, are very costly to serve, and will remain so regardless of setting. Even before the possible addition of more waiver services such as dental care, which is provided with far greater frequency in TCs than in the community settings that currently provide it, the cost difference will likely reverse for much of CVTC’s population as well as the medically fragile at the other TCs.
- There is no waiting list for TCs because ICF placement, a federal entitlement, cannot be waiting listed under federal Medicaid law. Furthermore TC admissions are not offered or even discussed but are strenuously suppressed by DBHDS. People have to exhaust all other options first, over the course of weeks and months, often declining all the way. Admissions are only reluctantly permitted in

desperate situations, usually after numerous inappropriate transfers, and then only for 21 days. Case managers have been instructed that TC admissions are not permitted. Even under such restrictive circumstances, CVTC has received a number of admissions since the Settlement Agreement was announced, since the community cannot provide appropriately intensive care for all.

- TC census numbers would not have declined so rapidly since 2012 had the state been fair and above-board with TC families. (For example, in February of 2012 Commissioner Stewart told a large group of assembled CVTC families that training center placements would no longer be among the residential choices available.) No discharges have been achieved through fully informed AR consent but only through less forthright means.
- CVTC offers the highest level of TC medical services (including a 5-star dual certified nursing/skilled nursing facility (NF/SNF), onsite diagnostic lab, onsite pharmacy, and 24/7/365 onsite physician staff) and has twice the census of SWVTC, three times the census of NVTC and four times the census of SEVTC -- hence the comparatively high operating budget. CVTC employs 167 RNs, LPNs and CNAs, 4 full time on-site MDs, 4 part time on-site MDs, and numerous specialists under contract, both on-site and off.
- Region 1 has the highest percentage of disabled people who are currently being served under the HCBS waiver and the highest percentage served at a TC, but if data are based on the CVTC census alone, the TC percentage for that region is misleading since CVTC is the only statewide facility and is home to residents from nearly all CSBs.
- DBHDS Social Workers estimate that there are over 400 training center ARs who will continue to withstand pressures and refuse community discharges, making the plan to leave only 75 TC beds in operation unrealistic.

2) Property Data

- CVTC's initial budget appropriation for FY2015 is \$77,030,617, or nearly \$5.5 million less than the actual FY2014 budget cited in this document.
- Other residential buildings are in use at CVTC in addition to those listed, including buildings 19, 20 and 30. Not all residents are on first floors, but most are, and residents continue to be moved to first floors as appropriate vacancies occur. Bannister Hall buildings have been redecorated but not renovated.
- CVTC renovation estimates are quite possibly inflated, as is the longtime DBHDS habit. Renovations to some Rapidan area buildings were achieved for less than half

of the DBHDS estimate, even though the new construction used some of the highest quality materials and design features available on the market, sparing no expense. And no other options are presented or costed, such as razing old buildings and constructing new, or using more moderately priced materials and/or reusing brick or other recyclables. Repurposing buildings for shared uses, such as locating offices above living areas, would yield further reductions in renovation costs, since DBHDS estimates are based on fully renovating every building in current use, despite recent upgrades. (The Administration Building is currently getting a new roof, for example.)

- Costs for comparable medical personnel and services, and comparable access, will increase in scattered community settings, as the state will lose CVTC's economy of scale (provided comparable specified community services and safety that are acceptable to CVTC ARs can be found.) The state will likely have to build and staff comparable alternative ICF and NF/SNF facilities if the plan to close CVTC continues, and this could only be achieved at additional unknown expense.

3) Settlement Agreement Background and Status

- DOJ invoked CRIPA (Civil Rights of Institutionalized Persons Act) to gain authority to investigate TCs. CRIPA sets standard of "egregious harm" as grounds for DOJ investigations; DOJ claims that simply living with other disabled people in a larger setting constitutes "egregious harm."
- Olmstead requires individual choice in residential setting, usually left out of all descriptions of that decision by DBHDS and other community-only advocates. Yet DBHDS does not respect even written statements by ARs indicating their firm and unalterable choice of continued TC placement and their requests to limit such placement discussions to the annual discussion required by the SA. Instead DBHDS claims that they are required to "inform" families of community alternatives -- sometimes monthly, sometimes even more often -- even when there is nothing new to offer or to say.
- The Primary Objective stated in this document includes "informed choice." DBHDS has yet to inform TC families of even the most basic and defining differences between ICFs and waiver placements, such as active treatment programs developed and monitored by interdisciplinary teams of treatment professionals, and the inherent differences in risks, oversight and accountability. By any definition, informed consent includes disclosure of risks. (The recent Medicaid HCBS "Final Rule" requires informed consent and state assurances that HCBS services will not cause harm. The Final Rule will be enforceable by CMS in March of 2019, though CMS encourages states to come into compliance as soon as possible.)

- Outstanding Issues: (1) Northern Virginia is not the only region with insufficient providers and services, although the impending planned closure of NVTC highlights that region's urgent need. Every region has serious shortages of providers who can offer comparable care and safety, a mandate of SB627. CVTC families face exactly the same provider shortages that exist in other regions of the state, including northern Virginia, since CVTC is the only statewide TC. Comparable safety will require changes in state law and enforcement of DBHDS licensing and other pertinent regulations. (2) Over time, as ARs become better informed through the efforts of the TC family organizations and more immune to the state's intimidation, fewer will accept community placements. (3) SB627 means that DBHDS will no longer be able to offer reduced clinical care in the community while claiming community programs are equal or better. Nor will the Department be permitted to move people from a training center that offers more intensive clinical services to one that offers less, unless the AR expressly waives comparable care. With the highest level of medical services and programs, CVTC people will not be subject to forced transfers to any other TC. (4) Bridge funding is a gamble. There is no guarantee that sufficient funding to maintain individuals discharged to the community will continue under the new waiver, if it is approved.

4) FAQs

- #1: ICFs are not fully defined, even leaving out the most basic distinctive: active treatment programs designed and monitored by interdisciplinary teams of treatment professionals.
- #4: Indications are that there are insufficient Licensing Specialists to achieve the safety goals of the Settlement Agreement. Donald Fletcher's 4th report to Judge Gibney states Licensing's over-reliance on case management records, which seem to gloss over findings since so few deficiencies are ever cited. There also appears to be an insufficient number of case managers – they have overburdened case loads. Licensing inspections were originally to be monthly for a year for those discharged from TCs, but that has been reduced to just one post-move inspection. Reduced frequency of face-to-face case management for certain people in the SA target group is being renegotiated with DOJ now. In summary, community oversight, always far less than at TCs, is now further reduced than originally planned and will likely even be reduced from current Settlement Agreement requirements. For most TC families, community risks far outweigh any possible benefits, and that is becoming even more problematic.

Important Cost Considerations:

1. According to a 2006 University of Minnesota Report to CMS*, based on a study of data reported by six states, the following cost conclusion was drawn: “Controlling for level of ID; health, physical and sensory limitations; behavioral, psychiatric and autism diagnoses; gender and age; and type of residence, ICF/MR [settings were a] predictor of higher expenditures. . . . **after controlling for the many other variables related to cost, [they] predict only an additional 3.3% of variation in expenses.** - Page 91.
2. According to the same University of Minnesota study referenced above, **those receiving daily medical care are costlier to serve in community settings.** The average annual medical care costs were reported as:

ICF/MR - \$128,527 HCBS - \$137,483 -- Page 77.

Costs for medical care have grown since 2006, and while the actual figures are undoubtedly out of date, the concept and cost ratio is not. With medical care costs greatly outpacing those of other services, the reversed cost gap, for the medically fragile, between training centers and the community is likely to have increased.

3. Among the various training center populations, CVTC’s is, on average, the oldest, most disabled, and most medically needy. CVTC’s nursing/skilled nursing facility provides superior intensive medical care and houses 68 individuals as of January 31, 2014. **Many others at CVTC and all of the other training centers require daily nursing, thus the potential for higher average costs in community settings is increased significantly.**

What does the author of the DOJ deinstitutionalization strategy, Sam Bagenstos, say?

“(A)s deinstitutionalization advocates shifted their goals from rights to services, the cost gap between institutional and community services narrowed... it is reasonable to expect that the cost gap will shrink as people in the community receive more services.... Once private settings such as nursing homes and group homes are thought of as institutions...the cost gap can narrow further or even in some cases reverse.” (*Nursing homes are even now considered institutions by CMS, as is the developing trend for higher capacity group homes.*)

* “Medicaid Home and Community-Based Services for Persons with Intellectual and Developmental Disabilities – Final Report, Prepared for the Centers for Medicare and Medicaid Services”, University of Minnesota Research and Training Center for Community Living, September, 2006

FROM MEDICAID.GOV, A FEDERAL WEBSITE:

Intermediate Care Facilities for Individuals with Mental Retardation (ICF/MR)

Intermediate Care Facilities for individuals with Mental Retardation (ICF/MR) is an optional Medicaid benefit that enables States to provide comprehensive and individualized health care and rehabilitation services to individuals to promote their functional status and independence. Although it is an optional benefit, all States offer it, if only as an alternative to home and community-based services waivers for individuals at the ICF/MR level of care.

IMPORTANT NOTE: Federal law and regulations use the term “intermediate care facilities for the mentally retarded”. CMS prefers to use the accepted term “individuals with intellectual disability” (ID) instead of “mental retardation.” However, as ICF/MR is the abbreviation currently used in all Federal requirements, that acronym will be used here.

Eligibility for ICF/MR Benefit

ICF/MR is available only for individuals in need of, and receiving, active treatment (AT) services. AT refers to aggressive, consistent implementation of a program of specialized and generic training, treatment and health services. AT does not include services to maintain generally independent clients who are able to function with little supervision and who do not require a continuous program of habilitation services. States may not limit access to ICF/MR service, or make it subject to waiting lists, as they may for HCBS. Therefore in some cases ICF/MR services may be more immediately available than other long term care options. Many individuals who require this level of service have already established disability status and Medicaid eligibility.

State Variation

Need for ICF/MR is specifically defined by states, all of whom have established ICF/MR level of care criteria. State level of care requirements must provide access to individuals who meet the coverage criteria defined in Federal law and regulation. In addition to level of care for AT, the need for AT must arise from ID or a related condition. The definition of related condition is primarily functional, rather than diagnostic, but the underlying cause must have been manifested before age 22 and be likely to continue indefinitely. States vary in practical application of the concept of related condition. In some states individuals applying for ICF/MR residence may be eligible for Medicaid under higher eligibility limits used for residents of an institution.

Services Included in the ICF/MR Benefit

ICFs/MR provides active treatment (AT), a continuous, aggressive, and consistent implementation of a program of specialized and generic training, treatment, and health or related services, directed toward helping the enrollee function with as much self-determination and independence as possible. ICF/MR is the most comprehensive benefit in Medicaid.

Federal rules provide for a wide scope of required services and facility requirements for administering services. All services including health care services and nutrition are part of the AT, which is based on an

evaluation and individualized program plan (IPP) by an interdisciplinary team. Facility requirements include staffing, governing body and management, client protections, client behavior and physical environment, which are specified in the survey and certification process.

Day Programs

Many ICF/MR residents work in the community, with supports, or participate in vocational or other activities outside of the residence, and engage in community interests of their choice. These activities are collectively often referred to as day programs. The ICF/MR is responsible for all activities, including day programs, because the concept of AT is that all aspects of support and service to the individual are coordinated towards specific individualized goals in the IPP.

Where ICF/MR Services are Provided

Medicaid coverage of ICF/MR services is available only in a residential facility licensed and certified by the state survey agency as an ICF/MR. Medicaid ICF/MR services are available only when other payment options are unavailable and the individual is eligible for Medicaid. There are few resources similar to an ICF/MR, under any payment source.

Institutional Care

- [Intermediate Care Facilities for People with Mental Retardation \(ICF/MR\)](#)
- [Nursing Facility \(NF\)](#)
- [Preadmission Screening & Resident Review \(PASRR\)](#)
- [Psychiatric Residential Treatment Facilities \(PRTF\)](#)



A federal government managed website by the Centers for Medicare & Medicaid Services. 7500 Security Boulevard Baltimore, MD 21244

Comments Submitted by Peter Kinzler, NVTC Family Member of the Work Group
July 1, 2014

The Relationship between the Americans with Disabilities Act, the *Olmstead* Decision,

The Settlement Agreement, SB 627 and the Work Group

I believe a thorough understanding of the relationship among the legal authorities that provide the parameters for the work group's actions is essential for the work group to meet its statutory mandate "to consider options for expanding the number of training centers that remain open, in whole or in part, in the Commonwealth." This memo is designed to flesh out the materials previously provided by the DBHDS to help focus the work group on the key questions that need to be answered to fulfill its responsibilities.

The ADA and *Olmstead*. The ADA and *Olmstead* establish the parameters for the Settlement Agreement (SA). In turn, the ADA, *Olmstead* and the SA provide the framework and permissible limits of what State laws, such as SB 627, can do. Together, they establish the scope of the work group. The following paragraphs describe the relevance of each to the tasks of the work group.

The Current Status paper circulated last Thursday properly states that, "The Supreme Court found that the segregation of persons with disabilities constitutes discrimination in violation of Title II of the Americans with Disabilities Act (ADA)." However, the description is incomplete. It fails to include Justice Ginsburg's discussion of the three requirements necessary to find that a State is required to provide community-based treatment for institutionalized individuals, one of which is that "the affected persons do not oppose such treatment."

Expanding on this right of choice, Justice Ginsburg added the following context in *Olmstead*:

[N]othing in the ADA or its implementing regulations condones termination of institutional settings for persons unable to handle or benefit from community settings. Nor is there any federal requirement that community-based treatment be imposed on patients who do not desire it.

* * *

[T]he ADA is not reasonably read to impel States to phase out institutions, placing patients in need of close care at risk. . . . For other individuals, no placement outside the institution may ever be appropriate. . . . Each disabled person is entitled to treatment in the most integrated setting possible for that person – recognizing that, on a case-by-case basis, that setting may be in an institution.

The Settlement Agreement. As the Current Status information says, the agreement is designed "to prevent the unnecessary institutionalization of individuals with ID/DD and to provide them

opportunities to live in the most integrated settings appropriate to their needs *consistent with their informed choice.*” (emphasis added)

The Current Status information also identifies the number of waiver slots the agreement requires. It is important to note that Virginia may provide a greater number of waiver slots than required by the agreement, as it did in FY 2012 and 2013, but it cannot reduce the numbers below the total amounts required by the agreement (the dramatic reduction in waiver slots in the FY 2015 budget does not violate the SA because the total number of budgeted slots for FY 2012, 2013 and 2014 exceeds, by a small margin, the totals for those three years required by the SA). The State is legally obligated to provide all 4,170 waiver slots, including the waiver slots for community placements, *regardless of the cost of providing care for the residents of the training centers.*

What the Current Status document does not discuss are the detailed rights of family choice to care in a State-run TC. Consistent with the ADA and *Olmstead*, the agreement provides:

Nothing in this Agreement shall prevent the Commonwealth from closing its Training Centers or transferring residents from one Training Center to another, provided that, in accordance with Virginia Code 37.2-837(A)(3), for as long as it remains effective, *no resident of a Training Center shall be discharged from a Training Center to a setting other than a Training Center if he or his Authorized Representative chooses to continue receiving services in a Training Center.* (emphasis added)

SB 627. The law contains two parts. The first requires DBHDS to certify that individuals leaving a training center will receive a quality of care that is “comparable to that provided in the resident’s current training center regarding medical, health, developmental, and behavioral care and safety.” As with the SA’s required number of slots, SB 627 does not place a price tag on such care.

The second part of SB 627 establishes the work group, with the mandate “to consider options for expanding the number of training centers that remain open, in whole or in part.” That is the sole purpose of the work group. The Current Status information includes some associated issues in its brief section on “Outstanding Issues.” The first one – “Barriers to closing NVTC and budgeted savings tied to closure” – misses the focus of SB 627, which is to look at options to keep the TCs open, not to close them.

Both of these provisions are, as they must be, consistent with the legal hierarchy – the ADA, *Olmstead*, and the Settlement Agreement.

The Work Group. The State plan to implement the agreement provides that only one training center, SEVTC with its 75 bed capacity, shall remain for those who want to continue TC care. Despite the enormous pressure DBHDS has placed on center families to leave the centers (telling many that if they don't accept a community placement by the closure date, their loved ones will be moved to another center hundreds of miles away from the family), DBHDS' own surveys show that more than 400 families wish for their residents to remain in a training center (See Appendix I). These statistics are a main reason why the General Assembly unanimously passed SB 627.

Since the SA gives ARs the right to choose ongoing TC care and the number who want such care exceeds the 75 slots set aside in the present State plan, where to provide such care is one of the key questions for the work group (this is another issue not mentioned in the Current Status documents). If more than one center needs to remain open to meet the demand, how many should remain open and in what configuration? Clearly, families want to keep their loved ones nearby, and the ability to support those remaining in TCs locally should be a significant consideration of the work group.

NVTC families have recognized for many years the need to reduce its present configuration to reflect the lower census. Thus, NVTC families participated in a Northern Virginia regional effort with a broad spectrum of stakeholders, under the guidance of Senator Barker and Delegate Bulova, which produced a Northern Virginia Regional Plan in 2010. (See Appendix II).

A more detailed vision and plan for evolution of the system for people with ID can be found in the Northern Virginia Regional Plan (See Appendix II.). It calls for selling some of the land and using the proceeds for others with ID. Not only would such land sales provide direct benefits to people in the community, they would also eliminate a substantial portion of the maintenance costs discussed in the document entitled "Property and Budget Information." More broadly, the plan calls for the dedication of more resources to the community with a downsized NVTC for the residents whose families wish for them to continue to receive care there. By preserving NVTC, the plan would open up many of its unique services to people with ID who reside in the community and have no access to such services.

Costs. While the materials circulated focus heavily on the Department's views of the costs of keeping the TCs open, it is important to remember that the SA requires the creation of 4,170 community slots, *regardless of cost*. Nonetheless, for the work group to report its findings to an

administration and legislature concerned with cost, it would be wise to identify the essential questions related to costs and provide some useful estimate of those costs.

These brief comments sketch some of the essential financial questions not addressed by the materials provided by the Department:

1. What would be per resident support costs for an efficient TC? These target costs would not include the present charges for discharge planners and the administrative costs of transition activities, nor would they include the cost of maintenance for unneeded facilities or grounds.
2. What are the full costs to taxpayers per resident for providing “comparable” quality of care in the community, as required by SB 627? These costs would include all direct Medicaid payments (for example, hospitalizations and physician services), costs not covered by Medicaid (such as dental care), and all CSB supplements (such as room and board and regional wage differentials, especially in Northern Virginia). Finally, in order to get the complete picture of transition costs, it would be necessary to separate out the costs for those going into nursing facilities, community ICFs/ID, and group homes with full time supports, from other types of supported residency.
3. What would be the transitional costs for TCs and the comparable transitional costs for the community? Although reconfiguring TCs will cost something, so will acquiring properly configured community ICFs/ID and group homes for those with complex needs.
4. What would it take to sustain IDD health professional specialists to serve both the TC and community residents who need these specialists? Both community and TC advocates recognize the essential needs served by a DD Health Support Network, a REACH crisis stabilization program, and a Quality Management program. All of these networks and programs must have stable funding and be reflected in the costs of serving their respective populations.

The Department’s materials do not address these essential cost questions. We know the costs of moving people from the TCs to the community will not be less than projected by the Department and that Virginia must create all 4,170 slots, regardless of their costs. Put another way, the actual costs of moving people from the TCs to the community will have no bearing on the State’s legal obligation to create the number of waiver slots called for under the SA for people with ID on the urgent waiting list and for people with DD other than ID. While costs are a legitimate issue for the State, what they actually are may be better left for the joint ad hoc subcommittee to determine, as required in the FY 2015 budget.

Appendix I – DBHDS Surveys of their Social Workers’ Views of AR Choices

Below are the results of two Department surveys of “Community Integration Preference Scores,” as required by legislation that passed in 2013. The DBHDS conducted the surveys by asking their social workers to estimate the residential choices of the ARs. The “Preference Score Definitions” remained the same in the two surveys, but the characterization of two of their categories changed from “absolutely not” and “no” in the first survey to “tentative, no” and “tentative, not responsive” in the second. There were 439 people in the two categories in the first survey and 400 in the second, as well as another 183 in the “maybe” category in the first and 197 in the “Need more information” category in the second (with the same definition as the maybe category in the first).



DBHDS
Virginia Department of
Behavioral Health and
Developmental Services

Community Integration Preference Score

	CIP Score 0 (yes)	CIP Score 1 (maybe)	CIP Score 2 (no)	CIP Score 3 (absolutely not)	Totals
CVTC	45	55	97	103	300
NVTC	32	39	36	28	135
SEVTC	16	13	34	21	84
SVTC	63	17	15	18	113
SWVTC	10	59	55	32	156
Totals	166	183	237	202	788

DBHDS
Virginia Department of
Behavioral Health and
Developmental Services

Community Integration Preference Score Definitions

Yes	0	No reluctance to community living, already in process at the ARs request or has chosen a home.
Maybe	1	Small amount of reluctance, however is willing to tour, receive education and will call back if contacted.
No	2	Apprehensive, difficult to stay in contact with, may communicate with a select few TC or CSB staff; does not want community placement, however may be able to persuade to tour with additional supports (to include family mentoring, FRC referral, etc)
Absolutely Not	3	Opposes community integration, refuses to tour or have conversations regarding further education about the process or community options; will not return phone calls to CSB or TC staff, and/or has chosen Training Center placement and will not entertain further conversations on the matter.

DBHDS
Virginia Department of
Behavioral Health and
Developmental Services

Update on Implementation of DOJ Settlement Agreement and Training Center Closures

Joint Commission on Health Care HL/HS Subcommittee
October 22, 2013

James W. Stewart, III.
Commissioner
Virginia Department of Behavioral
Health and Developmental Services

	CIP Score 0 (Yes)	CIP Score 1 (Need More Information)	CIP Score 2 (Tentative, Not Responsive)	CIP Score 3 (Tentative, No)	TOTAL
SVTC	48	14	10	15	87
NVTC	36	46	40	4	126
SWVTC	9	60	52	31	152

Comments Submitted by Peter Kinzler, NVTC Family Member of the Work Group
July 1, 2014

CVTC	44	62	79	110	295
SEVTC	7	15	34	25	81
TOTAL	144	197	215	185	741

 <h2 style="text-align: center;">Community Integration Preference Score Definitions</h2>		
Yes	0	No reluctance to community living, already in process at the ARs request or has chosen a home.
Need More Information	1	Small amount of reluctance, however is willing to tour, receive education and will call back if contacted.
Tentative, Not Responsive	2	Apprehensive, difficult to stay in contact with, may communicate with a select few TC or CSB staff; does not want community placement; however ,may be able to persuade to tour with additional supports (to include family mentoring, FRC referral, etc)
Tentative, No	3	Opposes community integration, refuses to tour or have conversations regarding further education about the process or community options; will not return phone calls to CSB or TC staff, and/or has chosen TC placement and will not entertain further conversations on the matter.

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Appendix II – the Northern Virginia Regional Plan
Recommendations for service delivery
within Region Two to enhance services
through collaboration for
individuals with intellectual disabilities

ISSUE: Stakeholders representing services for individuals with intellectual disabilities have joined together in Region 2 (northern Virginia) in order to review the current system of services. Through a review of current data, best practices and current system capacities and assets, the group studied existing support alternatives and identified limitations in order to build a future plan of services within the Region. A group of stakeholders met to discuss how service delivery could be coordinated among institutional and community settings for individuals with intellectual disabilities.

(Refer to **Attachment A** for membership list)

The group began by comparing Intermediate Care Facilities to Home and Community Based Waivers. The term Intermediate Care Facility for the Mentally Retarded (ICF/MR) was established in 1972 through amendment of Title XIX of the Social Security Act. An ICF/MR was defined to provide for the full array of needs for qualified individuals with intellectual disabilities (then referred to as mental retardation). In 1981, a further amendment of the Social Security Act (Section 1915c) established an alternative for the provision of long-term care known as “Home and Community-Based Waivers” (HCB Waiver). The term “waiver” acknowledged the choice which had been made available to individuals and their families to request a comparable level of community-based care instead of facility-based care provided through an ICF/MR. In 1991, Virginia began participation in this program by offering its first HCB Waivers.

The functional eligibility for a HCB Waiver is the same as that for an ICF/MR and this is determined through meeting the indicated dependency level in two or more categories on the “Level of Functioning Survey”.

While the diagnostic and functioning eligibility for both an ICF/MR and an HCB Waiver are the same, there is variance in the array of services, the funding mechanism, reimbursement rates and portability.

- ✓ In an ICF/MR, a full array of medical, behavioral, therapeutic and residential care is provided as needed for all residents of the facility or community based ICF/MR. In a HCB Waiver, an array of services is available but each individual must be pre-authorized to receive each specific service. Some services available to ICF/MR residents (such as nutritional and behavioral therapeutic supports) are not available through an HCB Waiver.
- ✓ An ICF/MR is funded at a per diem reimbursement rate based on the actual census. An ICF/MR serving 6 individuals would be reimbursed a set amount per day for each of the 6 individuals and that reimbursement would provide for all services. An HCB Waiver is individually pre-authorized so 6 residents of a Waiver funded home would each have their own level of Waiver authorization, varying in intensity and array of services included.
- ✓ An individual residing in an ICF/MR is approved to reside at a specific ICF/MR. An individual with an HCB Waiver may use that Waiver to seek services from approved Waiver providers anywhere in Virginia.

The Virginia Department of Behavioral Health and Developmental Services Comprehensive State Plan (2010-2016) states that Training Centers (State operated ICFs/MR) offer highly intensive and structured care environments for long-term, short-term and respite needs by combining medical and psychiatric assessments, preventive and general health care, medical stabilization and support necessary for successful community living. The report states that Training Centers currently serve individuals with co-occurring severe intellectual disabilities with pervasive physical disabilities or medical conditions as well as co-occurring moderate intellectual disabilities with mental illness and challenging behaviors. Regional Community Support Centers (RCSC) offer an array of dental, behavioral and therapeutic services and supports to individuals receiving community supports. (Refer to **Attachment B** for relevant historical information)

The group then reviewed relevant prevalence and financial data. Highlights are identified below:

- Region 2 has a population of 2.1 million out of a State total of 7.8 million

- Region 2 supports 169 individuals at Northern Virginia Training Center (April 2010)
 - Region 2 has 980 individuals on the wait list for the ID Waiver (April 2010)
 - Region 2 has 1,117 individuals assigned to Waiver slots (April 2010)
 - Virginia spent an average cost of \$165,106 for ICF/MR residents (<http://medicaid.ucp.org>) 2010 report
 - Virginia spent an average cost of \$56,783 for HCB Waiver recipients (<http://medicaid.ucp.org>) 2010 report
 - Virginia ranks 41st among States comparing ID/DD spending per capita at \$120 (<http://medicaid.ucp.org>) 2010 report
- (Refer to **Attachment C** for additional data)

The group also developed a set of values as guidance for their goals and recommendations.

(Refer to **Attachment D** for values)

After the group conducted a comprehensive review of both current service capacity and unmet service needs, they synthesized their findings into four areas of critical concern: crisis prevention, stabilization and restoration; physical and behavioral health; residential supports and day activity supports. While the group agreed upon these four distinct service areas, there was unanimous agreement of system needs which span across all service areas. Specifically, the group recognized that in order for any system change to be effective, the following are critical components:

- Virginia must reduce service silos in order to provide more seamless transition and access to services across the life span of individuals with disabilities
- There must be collaboration among consumers, families, advocates, service providers, public agencies, and the business, educational and health care communities
- Virginia must provide additional public funding, not limited to Waiver slots, in order to support the needs of those who are not eligible for Waiver slots and to support those services which are not funded by Waiver slots

(Refer to **Attachment E** for details of these reviews)

The group next developed both short term and long term goals.

GOALS:

- Virginia funding commitment should correlate to its wealth as a State and should strive to eliminate current disparity between State wealth and spending for individuals with disabilities
 - Short term goal: Increase per capita spending in Virginia from current level of \$120 per capita to \$145 per capita, representing a 21% funding increase.
 - Long term goal: Increase per capita spending in Virginia from current level of \$120 per capita to \$171 which is at the US average of spending per capita, representing a 43% funding increase.
- Eliminate Wait List within 5 years. Recognizing that recent economic crises have affected all States in their abilities to maintain services, it must be recognized that without a continuing responsive commitment to eliminate the wait list, the number of unserved individuals will significantly rise.
 - Short term goal: Allocate sufficient slots (minimum of 1000 annually) on an ongoing basis to eliminate the wait list within 5 years while addressing continuing growth of the wait list. If there is not an annual allotment of slots to strategically reduce this number, it is projected to increase to over 8,000 within 5 years just due to growth.
- Provide funding to expand the RCSC to provide medical, respite, and behavioral stabilization as outpatient services and long term skilled nursing services as inpatient services.
 - Short term goal: Modify license at NVTC to add outpatient services which can be billed to Medicaid. These services could then be provided without requiring admission to NVTC as an ICF/MR. Adequate funding must also be provided to expand the delivery of these services.
 - Short term goal: Modify license at NVTC to add skilled nursing care services through establishment of skilled nursing facility beds, separate from ICF/MR beds. Adequate funding must also be provided to expand the delivery of these services
 - Long term goal: Expand RCSC services beyond the Braddock Road property in order to better serve citizens in Western Fairfax, Prince William and Loudoun Counties.

- Enhance a Safety Net to provide medical, respite, behavioral and medical stabilization, and long term skilled nursing services within our community

Short term goal: The Regional Group acknowledges the legislative language introduced by Senator Barker (Item 314 #1c) which states that “The Commissioner, in cooperation with the Virginia Association of Community Services Boards and the Northern Virginia Training Center (NVTC), shall develop a pilot project to serve individuals in the community who otherwise might be admitted to NVTC. The pilot shall include a review of evidence-based community services that have proven cost effective in reducing the demand for placement at NVTC or other similar facilities. The pilot project shall have no effect on the status of individuals currently residing at NVTC. The Commissioner shall report his findings and recommendations to the Chairmen of the Senate Finance and House Appropriations Committees by November 1, 2010.”

As NVTC decreases its size due to more discharges than admissions, funding should be diverted to increase the capacity to meet the needs for respite, crisis stabilization, medical care and skilled nursing. NVTC must be able to diversify its design, its funding support and its license and accreditation to operate simultaneously as an ICF, a SNF and an outpatient site.

Long term goal: This pilot must be expanded to accommodate the needs of residents in Western Fairfax, Loudoun and Prince William for whom access to NVTC is difficult. This can be accomplished through partnering with these communities to identify available properties and facilities for RSCS expansion.

- Reduce system fragmentation which exists through “service silos” which are compartmentalized based on historic definitions of disabilities or types of service.

Short term goal: Support State activities to broaden the service definition of eligible individuals from intellectual disabilities to developmental disabilities. Developmental Disabilities include intellectual disabilities but more broadly also include disabilities which are manifested during childhood such as autism, cerebral palsy, brain injury and spina bifida. As a reference, there are nearly twice as many

students with autism as there are with intellectual disabilities. State funding must be increased commensurate with the increase in eligibility levels to prevent a larger number of individuals competing for an inadequate amount of funding support.

- Promote public/private collaboration including families, businesses, non-profit agencies and public sector for maximum leverage.
 - Short term goal: Establish a Strategic Planning and Action Group to be comprised of consumers, families, advocates, service delivery providers, CSBs and NVTC. This Action Group would also conduct outreach to businesses, corporations, medical professionals, education systems and early intervention systems to coordinate training and education resulting in collaborative service enhancements.
- Review reimbursement rates to improve staff retention and ensure quality of service provision.
 - Short term goal: Waiver reimbursement methodology should be tiered similar to the reimbursement system for nursing homes to ensure that providers receive adequate reimbursement based on the specific individual needs of their recipients.
 - Short term goal: Public funding should be increased to include those individuals who are not Waiver eligible as well as for those services which are not Waiver funded.
 - Short term goal: Waiver reimbursement rates must be adjusted regularly to reflect consumer price indices.
 - Short term goal: Waiver reimbursement units should be increased to allow maximum flexibility for providers. Rather than reducing the units to 15 minute or 1 hour intervals, the rates should be broadened to be more inclusive of general supervision and overnight support to ensure health and safety.
- Maximize the value of the property and land at 9901 Braddock Road by assessing the feasibility of its direct usage, “land swapping”, or its development value.
 - Short term goal: Obtain a property assessment of land and buildings at 9901 Braddock Road from an independent evaluator.
 - Short term goal: Assess the current infrastructure to determine the viable structure(s) needed to continue to provide supports to NVTC residents.

This assessment by NVTC or DBHDS staff shall also address the viability of any structure(s) which could be licensed as a skilled nursing facility.

- Long term goal: The remaining land and structures, as identified in the infrastructure assessment, which are not needed for current NVTC residents, RCSC outpatient services or a skilled nursing facility, will receive an additional review. This review will identify how to best maximize these available resources to support the Region's needs. (Examples may include community residential homes built on site, "land swapping" to meet Regional needs in other parts of the Region, or selling land to develop resources in underserved areas of the Region.

Members of the group who were not public employees have also recommended fiscal initiatives by elected State officials to:

- Maximize federal funding participation in order to maximize leveraging of federal funds
- Empower localities to impose local taxes to fund targeted services
- Increase the allowances for non profit agencies to have tax exempt status for local property taxes