

**Comments on DBHDS Materials Provided
for SB627 Work Group August 4, 2014 Meeting**
Submitted by Jane Powell, President of CVTC Families and Friends

Draft List of Work Group Factors:

Factor #6 is simply about geographic proximity of training center residents to their families and any other individual community supports they may have.

Factor #4 should be a consideration of comparative costs for comparable services under the new waiver, for those who choose to accept it, and ICF/IID costs, whether training center or smaller community ICF/IID. The latter will be necessary to replace closed training centers for those who will not accept waivers.

Factor #7 is subjective and cannot be quantified.

Overall, I concur with Peter Kinzler's opinion that the law, both state and federal, must take precedence in all factors and all options this work group will consider, as must the hundreds of ARs choosing continued TC care.

Cost Reporting for Training Centers:

This would be far more relevant if training center costs were compared with equivalent service costs in community settings. As is, many things are included that must be provided in any setting with similar costs and are therefore irrelevant to a cost comparison, except for comparable community services that are not provided under the waiver, as is the case with transportation and dental care.

Side-by-side comparisons with community costs for comparable services (other than such items as food, barbering and laundry, which must be provided at about the same rate anywhere) would be far more informative. All services provided at training centers are needed and must be provided, so what do they cost outside of the TCs? Do private hospitals charge more or less for radiology and pathology, for example? What is the cost of replicating CVTC's nurse to patient ratio, or onsite physicians 24/7 in scattered small community settings? Cost-capped waivers would not cover the expense, thus ICF/IID services are required. It is a mandate of federal law that waiver costs cannot exceed the cost of ICF/IID care, so waivers are intentionally cost-capped and therefore cannot provide a comparable intensity or availability of services.

Is there a cost associated with religious activities? If so, is it unique to training centers?

"Education and Training" are ICF/IID imperatives, as are occupational, speech and activities therapies, as components of the ICF/IID active treatment requirement. So are transportation, prevocational services, and most of the rest. As ICFs, the training centers must provide all services themselves. How many of these services in the community are provided under different payment sources and are therefore cost-shifted to different agencies? And at what cost?

"Staff Development and General" category may include the cost of dedicated discharge personnel whose function is of no service to TC residents.

Medical services, Psychology, Dentistry, and other services that are provided at the RCSCs are of no benefit to TC residents – on the contrary, they are community services that are provided by training centers.

Mortality Facts:

This document is seriously flawed. (Please see the document provided by Dr. Anthony.) Conclusions implied by flawed statistics are erroneous. The more pertinent – and unanswered -- questions are: Why and how did those discharged from TCs die and how quickly after discharge? Have protocols for discharge been changed, indicating a former recklessness associated with the rushed timetable and annual discharge quotas? Were deaths expected or unexpected? How many were in fragile health? How long had their former TCs kept them alive in fragile health? How about serious injuries requiring physician attention in each setting?

There are relevant harms less dire than death to consider as well. What is the comparative neglect rate? How many have been returned to TCs for behavioral reasons, due to inadequate crisis services? What is the rate of individual need for a more structured setting, especially where autism is present? How many group homes have evicted residents with 30 days' notice in the past year? What is the comparative incidence of life-threatening pressure ulcers? What is the comparative rate of shootings, beatings, untreated serious scaldings, etc.?

The latest APS figures online are for 2013:

- 9075 APS reports were determined to be founded. Many other reports did not meet criteria for investigation. Reports of abuse, neglect and exploitation have been increasing over the years.
- Victim breakdown: 29% were aged 18-59 and incapacitated. (Age 60 and older, incidents are not reported separately for disabled and nondisabled populations.)
- Substantiated cases of abuse, neglect or exploitation occurred 214 times in DBHDS licensed residences. 6277 substantiated incidents occurred in the victim's own home.

Link to a resource revealing the extent of abuse and neglect in community settings nationwide, revealing serious problems in Georgia – the state after which Virginia's DOJ Settlement Agreement was modeled:

<http://vor.net/images/AbuseandNeglect.pdf>

Waiver Services by Home- and Community-Based Waiver:

Everyone is in agreement that the current waiver is inadequately funded for TC people. Services are cost-capped under the waiver, whereas ICF/IID services are not.

DBHDS Settlement Agreement Model:

Forecasts of cost savings to the state resulting from TC closures are based on assumptions that have repeatedly proven to be false. Hundreds are choosing to remain in training centers, community costs have been significantly underestimated time and again, and facility closure dates are unrealistic given the lack of actual availability of adequate and acceptable alternatives. Time to either adjust the assumptions or discard them for facts.