Testimony before the General Assembly
Special Joint Subcommittee to Consult on the Plan to Close State Training Centers
Wednesday, September 2, 2015

Community Services Board's Perspective of Community Transitions

Good Afternoon. My name is Jean Hartman. I am the Assistant Deputy Director for the Fairfax-Falls Church Community Services Board. The Fairfax-Falls Church CSB provides and coordinates a system of community-based supports for individuals and families of Fairfax County and the cities of Fairfax and Falls Church. Thank you for the opportunity to speak before the Special Joint Subcommittee today about the Community Services Board's perspective and experience with transitions from training center to community.

The Fairfax-Falls Church CSB has been the jurisdiction with the largest number of individuals for whom the Northern Virginia Training Center has been their home. In 2012 when the Department of Justice and the Commonwealth came to a Settlement Agreement, we had 89 individuals living at NVTC. Currently 34 of the 54 individuals remaining at NVTC are from Fairfax-Falls Church and another 14 live at CVTC.

On the one hand, we are fortunate that some 530 individuals with intellectual disability are already living in the Fairfax-Falls Church community with the assistance of a range of supports provided by experienced residential and employment and day providers. Individuals may have chosen to live in one of the 71 group homes, 7 intermediate care facilities, 37 supported residences, or 4 sponsored "host" homes; or they may be among the 100 individuals receiving supportive services in their private residences. At first blush we sound flush with an abundance of resources and options, but there is "another hand".

On the other hand, these dozen or so experienced residential providers were already fully subscribed when the decision was made to close NVTC. So, individuals in the community already awaiting residential services are now also in competition with those individuals currently residing in state training centers whose imminent service in the community is mandated by the Settlement Agreement. The reality of Northern Virginia's high property and operational costs combined with the uncertainty around Waiver reform funding, has made it difficult for providers to structure expansion plans. Thus we have been challenged to expand community capacity paced with the training center closures.

Nevertheless, (on the third hand) we *have* been able to expand community capacity with existing community partners and welcomed new partners. There will soon be 17 residential providers in Fairfax-Falls Church and providers have expanded services. Through Section 811 and Section 8 Housing Choice Vouchers, with Home Investment Partnership, in collaboration with other County agencies, and in joint projects with the City of Falls Church or housing partners like Marion Homes Knights of Columbus and others; providers have opened or are in the process of opening new homes, ICFs, and apartment options. The Department's Bridge funding has also been an important resource in this effort.

Of the 56 Fairfax-Falls Church individuals who have transitioned from NVTC to the community since late 2012: 42 individuals were served by nine different providers within Health Planning Region (HPR) II. 14 individuals or a quarter thus far, moved outside of Region II. Of the 34 NVTC individuals yet to move to the community, only 5 will be going outside of Region II. (4 to an ICF operated by RACSB and 1 to a group home in Fredericksburg.)

The numbers I've presented in today's testimony are important, but only to the extent they help portray the human experience of individuals' and families' lives that are significantly impacted, and forever changed by the transitions we are discussing. The word "transition" is intentional. It is meant to capture the thorough before, during, and after components of a successful and safe transition of the individual with all their supports into the community. It is not just a matter of moving, of relocating. It is not a simple flip of the switch where "now you live here" and "now you live there". The CSB's work very closely with the interdisciplinary staff at the training centers, individuals, families, and providers to thoroughly plan, implement, and carefully assess and follow up each transition. So, let me close with a few individuals' transition stories.

Mr. A. transitioned from NVTC to a group home in February of this year. The transition was not easy for Mr. A. and after the first month of decreased appetite and fluid intake, he was hospitalized. The hospital sought to start a feeding tube, but the family objected as they believe the problem was due to the individual's reaction to all the changes. The CSB Support Coordinator joined with NVTC staff to meet with the family, individual, and residential provider at the hospital and in the home. They provided doctor-to-doctor consultation to the hospital, reviewed the supports, and worked with the residential staff to model interactions and clarify preferences and choices. The family was exceptionally pleased with the rapid and comprehensive support and the turnaround they effected, such that Mr. A continues to do well in his new home.

Ms. F is a 43 year old woman who had lived at NVTC from the age of *five* until last December when she moved to a group home in Culpepper nearer to her family. Ms. F's overall functioning is in the severe intellectual disability range. She has cerebral palsy, is non-ambulatory and nonverbal. After 38-years living in the training center, Ms. F's family was initially understandably reticent and concerned about whether her specialty medical care and equipment needs could be met in the community. But after a well-planned transition, Ms. F's family now observes that they "have never seen our daughter as sociable or animated" and that though they originally prayed NVTC wouldn't close, they now consider the "unanswered prayer a blessing".

We are fortunate to live in a community enriched by the lives of many individuals with intellectual disability who are supported to live rewarding and full lives in the community. Several of these individuals transitioned from training centers years ago, some are new neighbors. The CSB believes that a full life in the community is possible for all individuals with *careful* planning and *resourced* supports.

Thank you again for this opportunity and for your commitment to and investment in a life in the community for individuals with intellectual disability.

Testimony to the Joint Subcommittee on Training Centers

Alan Wooten, Executive Director, Prince William County CSB
Wednesday September 2, 2015

Good afternoon Members of the General Assembly and thank you for the opportunity to speak before you today. My name is Alan Wooten, and I am the Executive Director of the Prince William County Community Services Board, which serves residents of Prince William County and the Cities of Manassas and Manassas Park. I am here today to provide you a very brief summary of the transition of Prince William County residents from the Northern Virginia Training Center (NVTC) to community placements since 2012.

In 2012, there were 23 Prince William County residents residing at the NVTC. Since then, 16 have moved into community-based residences. Of the 16 that moved out, 11 moved to homes in the area and 5 moved to homes outside of the area at their families' requests. Today, there are 6 individuals remaining in residence at NVTC. Providers have been chosen for 3 individuals with move dates scheduled by the end of October. The provider selection process continues for the 3 remaining individuals. In addition to NVTC, there are 3 individuals from Prince William County who live at the Central Virginia Training Center. These individuals have significant physical and medical needs, and providers have not been identified for them at this point in time as we have been prioritizing NVTC residents given the shorter timeline for closure.

Prince William County's plentiful and more affordable housing market compared to other jurisdictions within northern Virginia has contributed to the increased number of service providers and increased service capacity in our County for over the past decade. As a result, our CSB has accepted responsibility for many persons with Medicaid waivers who have moved into Prince William County from our other CSB jurisdictions in northern Virginia. While this has added to the CSB's need for additional staffing to accommodate the high numbers of persons moving into our County for which we are responsible, we consider

ourselves fortunate to have a provider base that is well-aware of and experienced in meeting the unique needs of individuals with disabilities and that has demonstrated a willingness to explore every option possible to meet those needs. With that being said, sufficient funding to meet the needs of individuals and provide quality care is an essential ingredient in the recipe for successful community living.

Some of our providers have sought additional funding, such as community development block grant and private foundation funding to expand, adapt and enhance housing, to increase staff resources, to acquire needed specialized adaptive equipment, and to expand the array of services to meet individualized needs. Bridge funding has been essential to providers to afford necessary program enhancements and start-up costs to ensure smooth, safe and positive transitions from NVTC to the community.

I think it is accurate to say that the majority of the individuals our CSB has transitioned into the community from NVTC have high needs for personal assistance and supervision, and that many are physically and medically fragile. However, the transitions overall have been both positive and successful, which we attribute in large part to the extensive communication, collaboration and careful planning among CSB staff, NVTC staff, family members, and providers throughout the discharge planning process. Developing thorough and thoughtful plans of care, ensuring all resources are identified and in place prior to transitioning, and implementing strong systems of accountability are other key ingredients for success.

I want to leave you with two short success stories:

In April 2013 our CSB transitioned a person from NVTC who has a profound level of ID, autism, behavioral challenges (including PICA) and some medical issues. This person was transitioned into the community via Money Follows the Person (MFP) funding. The residential provider has nursing staff to monitor his health challenges and the day support provider has expertise in managing challenging behaviors. In addition, behavioral consultation was obtained from a third private provider. This individual is accessing his necessary medical care in

the community, including psychiatry and an ear, nose and throat specialist. He enjoys regular visits from his family, enjoys celebrating holidays and birthdays, swimming at the local recreational center, and became a member of a community church and was baptized several months after moving into his new home.

In August 2014 another person with very high needs moved into a community group home in our County. He is diagnosed with a profound level of ID, spastic quadriplegia, dysphasia, epilepsy, and congenital heart disease. He must use a gastrointestinal tube for feeding and has a history of being prone to pneumonia. Both his residential provider and day support provider have nursing services on staff. He receives the following specialty medical services from community providers: endocrinology, gastroenterology, neurology, dermatology, pulmonary and nutrition. He enjoys taking walks in his neighborhood, movies and shopping. His grandparents visit him frequently and when they are away from the area, a family friend checks in to visit and to make sure he is okay.

Thank you again for this opportunity to speak today and thank you for your service to all the citizens of the Commonwealth.