Speaking out for people
with intellectual disabilities

Toll free
877-399-4867

www.vor.net

Executive Director
Julie M. Huso
836 S. Arlington Heights Rd, #351
Elk Grove Village, IL 60007
605-370-4652 Voice
605-271-0445 Fax
jhuso@vor.net

Dir. of Govt. Relations & Advocacy
Tamie Hopp
PO Box 1208
Rapid City, SD 57709
605-399-1624 Voice
605-399-1631 Fax
thopp@vor.net

Washington, D.C.
Larry Innis
529 Bay Dale Court
Arnold, MD 21012-2312
410-751-1VOR Voice/Fax
LarryInnis@aol.com

April 5, 2012

The Honorable Judge Gibney
Judge, U.S. District Court
Spottswood W. Robinson III and Robert R. Merhige, Jr., Federal Courthouse
701 East Broad Street
Richmond, VA 23219

Re: VOR Comments in response to *United States of America v. Commonwealth of Virginia*, Civil Action No. 3:12-CV-059

Dear Judge Gibney,

Thank you for your willingness to hear from individuals and organizations regarding the January 26, 2012 proposed settlement between the U.S. Department of Justice (DOJ) and the Commonwealth of Virginia in Civil Action No. 3:12-CV-059.

VOR is a national, nonprofit advocacy organization for persons with intellectual and developmental disabilities (ID/DD) and their families and legal guardians. We have thousands of members across the country, including more than 100 individual members and five Virginia-based organizational members. These organizational members represent more than 1,000 training center residents and their families. We appreciate this opportunity to share our perspective.

Summary of Comment

VOR urges this Court to reject the proposed settlement as written. VOR submits that the Commonwealth's proposed settlement agreement with DOJ, including the submission of a plan to close centers and the manner in which they will close, shifts an otherwise "political" decision squarely within the realm of this court's review.

The proposed legal agreement unfairly impacts and potentially harms training center residents, the most vulnerable of Virginia's citizens with disabilities, who were not consulted or provided information as to the specific provisions which directly impact their rights as provided by Americans with Disabilities Act (ADA) / *Olmstead*, Medicaid and state law. Lessons learned in other states, coupled with the Commonwealth's faulty cost savings expectations, make tragedies predictable if the settlement is approved and closures implemented.

For these reasons, as further detailed below, VOR respectfully asks this Court to reject the proposed settlement either outright or with correcting amendments.

<u>The Parties Intend for the Settlement Agreement to Legally, not "Politically", Require Training Center Closures</u>

The express intent of the proposed settlement agreement is to "ensure the Commonwealth's compliance with the ADA and *Olmstead*, which require that, to the extent the Commonwealth offers services to individuals with intellectual and developmental disabilities, such services shall be provided in the most integrated setting appropriate to meet their needs." To accomplish this intent, the Commonwealth plans to close four of its five training centers and so fundamentally change the purpose of the fifth that all current residents will be displaced.

VOR is wholly unconvinced that the parties did not intend for the settlement to mandate the closure of training centers. The letter of the proposed legal agreement, including but not limited to Section III (C)(9) (calling for the submission of a plan to close training centers), concurrent representations by state officials to Virginia lawmakers indicating closure was mandated, and past pattern and practices by DOJ in other states[1] all point to closure as one intended outcome. The intent to close training centers coupled with court-enforced provisions within the settlement to accomplish closure, such as quotas for transition based on earmarked HCBS waiver slots and an entire section devoted to "Discharge Planning and Transition from Training Center" (Section IV), can lead to only one conclusion: the settlement legally requires closure. There is nothing in the Agreement that conditions Section IV on the General Assembly's acceptance of the closure plan submitted by the Commonwealth. Presumably, the Commonwealth will be required to implement "Discharge Planning and Transition from Training Center" provisions irrespective of General Assembly support and be subject to steep sanction fines if found to be in noncompliance.

Closure of training centers, therefore, is an inevitable legal outcome if this settlement is approved by the court. Unless the settlement is amended and stripped of all closure provisions before approved by the court, training center residents will be irreparably harmed, contrary to their state and federal rights:

> **Olmstead v. L.C., 527 U.S. 581 (1999)**: *Olmstead* provides rights to training center residents (not community-based individuals) to receive care in the most integrated setting appropriate to individual need based on the opinion of the individuals' treating professionals and individual choice. The Supreme Court cautioned against unjustified displacement: "We emphasize that nothing 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." <u>Id</u>. at 602 (*see also*, "Thus, the argument made by Arc and the United States [*Department of Justice*] who filed regarding the risk of institutionalization fails to account for a key principle in the <u>Olmstead</u> decision: personal choice. And here, where more residents desire to remain in institutional care than the new facility can provide for, there is little to no risk of

[1] In DOJ actions, purportedly to "enforce" *Olmstead* in Georgia, Illinois, Arkansas and Virginia (*Arc of Virginia v. Kaine* (2009)), the legal "relief" sought or supported by DOJ's Civil Rights Division has been the displacement of fragile individuals from life-sustaining, federally-licensed supports ("deinstitutionalization") without regard to choice and with little apparent concern for outcomes.

institutionalization for those whose needs do not require it and who do not desire it." Arc of Virginia v. Kaine (December 2009).

Medicaid: The Commonwealth must provide satisfactory assurances that "such individuals who are determined to be likely to require the level of care provided in a hospital, nursing facility or intermediate care facility for the mentally retarded [ICF/MR] are informed of the feasible alternatives, if available under the waiver, at the choice of such individuals, to the provision of inpatient hospital, nursing facility services or services in an intermediate care facility for the mentally retarded." 42 U.S.C. §1396n(c)(2)(C); see also, 42 C.F.R. §441.302 (An ICF/MR recipient or her legal representative will be – "(1) Informed of any feasible alternatives available under the waiver, and (2) Given the choice of either institutional or home and community-based services.")

Virginia Law: "Pursuant to regulations of the Centers for Medicare & Medicaid Services and the Department of Medical Assistance Services, no consumer at a training center who is enrolled in Medicaid shall be discharged if the consumer or his legally authorized representative on his behalf chooses to continue receiving services in a training center." Va. Code. Ann. § 37.2- 837(A)(3).

A Full Array of Residential Care Options is Required to Meet the Diverse Needs of Individuals with ID/DD; Required by Law

It is questionable whether the terms of the proposed settlement with regard to assessments for discharge of training centers are consistent with these federal law and regulations.

VOR members in Virginia and nationally support VOR's core mission in support of a full array of residential options to meet the diverse needs of individuals with intellectual and developmental disabilities.

VOR expressly eschews "group think" – the notion that ***all*** individuals with ID/DD should be served only in community-based settings without regard to choice, need and availability. Our support for a full array of services is based squarely on the principle of person-centered services for the heterogeneous ID/DD population and our strong support for individual and families as primary decision-makers regarding services, supports and policies. Our society would not force *all* seniors to live in the same residential model, or force *all* hospitals to do away with intensive care units in support of home-based health care, or force *all* parents to make uniform decisions with regard to their families' health care providers or neighborhood. VOR feels strongly that these same closely-held societal values and respect for individual decision-making must extend to individuals with ID/DD and their families.

The law supports VOR's unique[2] but informed organizational perspective. Choice matters and the decisions of individuals and their families are considered primary. Their insights into care

[2] VOR is the only national advocacy organization that supports a full array of residential options. Other organizations, including some who have made presentations to this court, seek the closure of all ICFs/MR, including Virginia's training centers (see e.g., Brief of *Amici Curiae* on behalf of The Arc of Virginia, et al., In Opposition to

needs, especially when considering the needs of training center residents, some of whom have the intellectual capabilities of infants, are unmatched:

> ". . . close relatives and guardians, both of whom likely have intimate knowledge of a mentally retarded person's abilities and experiences, have valuable insights which should be considered during the involuntary commitment process." *Heller v. Doe*, 509 U.S. 312 (1993) (see also, Developmental Disabilities Assistance and Bill of Rights Act, 42 U.S.C. 15001(c)(3)(2000): "Individuals with developmental disabilities and their families are the primary decisionmakers regarding the services and supports such individuals and their families receive, including regarding choosing where the individuals live from available options, and play decisionmaking roles in policies and programs that affect the lives of such individuals and their families"; and *Olmstead,* as discussed *supra*, at 2)

Federal Medicaid regulations also require the development of an annual, person-centered "individual program plan" assessment for every training center resident, developed in consultation with the resident and his or her legal guardian (often a close family member). (42 U.S.C. §440(c)). Likewise, the *Olmstead* decision requires deference to the opinion of "treating professionals" who have participated in the residents' comprehensive functional assessment or creation of the residents' individual program plans.

Of all Virginia Citizens with Disabilities, Training Center Residents are Among the Neediest, Most Fragile, and Most Disabled

Training Centers (ICFs/MR) are often the best, most cost-effective way to meet the needs of the most vulnerable of the population with intellectual and developmental disabilities. Their extreme disabilities and complete functional dependencies are remarkable[3]. They need support in every aspect of life including walking, communicating, bathing, eating and toileting. Nearly 70% cannot verbally communicate basic desires and more than 60% have two or more disabling conditions.[4] This Court heard from many families whose loved ones are profoundly disabled:

> Jason has Angelman Syndrome deletion positive which is a spontaneous mutation genetic disorder affecting the 15th chromosome. As a consequence, Jason's intellectual development is at a six-month to one-year old baby's level, is not toilet trained, is entirely non-verbal, has only a momentary attention span, tends to put everything in his mouth and chew on items that become choking threats (a condition called pica), and when excited and agitated, is prone to grab and hold onto whoever is nearby. Although Jason has profound intellectual disabilities, at age 36 he is able to walk, is quick, and has significant strength. Moreover, he has an exceptionally high pain threshold as illustrated

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Motion to Intervene (Appendix A)("The Arc believes that people with intellectual and developmental disabilities belong in the community and have fundamental moral, civil, and constitutional rights to be fully included and actively participate in all aspects of society").

[3] Seeing is believing. We support this Court's intent to tour a training center to meet the residents and see firsthand their needs and the compassionate services they receive. We respectfully encourage you to visit more than one training center as each training center community offers a unique perspective.

[4] "Residential Services for Persons with Developmental Disabilities: Status and Trends Through 2010,"Research and Training Center on Community Living Institute on Community Integration/UCEDD, College of Education and Human Development University of Minnesota (2009) (http://rtc.umn.edu/docs/risp2010.pdf)

> by not showing any symptoms of pain, not even a whimper, after having broken his collarbone a few years ago. (Jane Anthony, Letter to Judge Gibney, February 11, 2012).
>
> Brian is totally dependent on his caregivers for all of his activities of daily living (ie) bathing, continence, dressing, transferring, toileting and eating. He needs care 24/7/365. His medical conditions which have mostly been caused by his physical disabilities include two rods in his back to aid in his postural positioning so he won't be in constant pain, GERD, allergies to milk products, severe arthritis in both hips with loss of joint space, bladder cancer and seizures. He is in need of medical services, transportation to his daily job, nutritional services, physical therapy, occupational therapy, dental services, social work, therapeutic recreation, and communication services. (Peter McDonald, Letter to Judge Gibney, February 2012).
>
> Over the years Teresa has exhibited violent behavior and for most of her life these outbreaks have been regular and consistent. She has hit, pushed and bitten other residents at SVTC, the staff there and her family. She has tried to put a piece of glass in my eye. She has broken things. She has swept a strainer full of dishes off the counter on a home visit and she has turned her bed over. During attempted outings she has ripped a water fountain out of the ground and toppled displays . . . Teresa has diabetes, high blood pressure, glaucoma and a susceptibility to inflammatory gum disease. These nurses take her vitals daily, give her medicine and administer eye drops. Her caretakers, working closely with the dental clinic at SVTC, have returned her gums to health and are able to sustain it. (Letter from Julie Koury, March 15, 2012).

Training centers, as Medicaid-licensed ICFs/MR, are designed to care for citizens with profound disabilities. ICF/MR care simply cannot be replicated in unlicensed community-based settings at a lesser cost. Training centers provide cost-effective, comprehensive and individualized health care and rehabilitation services to individuals whose disabilities are profound:

> "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. . ." (CMS,"Intermediate Care Facilities for Persons with Mental Retardation (ICF/MR); see also, 42 U.S.C. §440(b) (To be eligible for ICF/MR services, residents must be in need of, and receive, "active treatment."); and 42 U.S.C. §440(a)(1) and (2) (Active treatment refers to aggressive, consistent implementation of a program of specialized and generic training, treatment and health services, and does not include services to maintain generally independent clients who are able to function with little supervision and no active treatment)

If Displaced from Specialized ICF/MR (Training Center) Homes, Tragedy is Predictable

Proposed Intervenors, letters from families, and communication from providers all point to dangerously inaccurate cost assumptions[5] and inadequate community capacity. Lessons learned from Virginia and other states make tragedies predictable.

VOR attributes unrealized cost savings associated with closures to the present underfunded community system of care in many, many states with resulting death, abuse and neglect in community settings. The cause of these well-documented, community-based tragedies is generally linked to the rapid expansion of community programs over the past decade; inadequate access to health care; the lack of adequate staff training and competency (attributed to low wages and qualifications); the lack of state and federal oversight; and the lack of adequate funding.[6] The *Virginia Pilot* reported on this problem in its special report, "*Virginia's Treatment of the Mentally Disabled*":

> Was it truly their time to die, or could their deaths have been prevented? The answers are difficult to find, mostly because the state, which used to be the primary caregiver for the mentally disabled, has surrendered much of that role to a patchwork system of community-based programs, such as group homes. The homes, 106 of them in South Hampton Roads, operate with low-paid, minimally trained workers. They churn along with a steady stream of money from the state and federal government, but with little oversight from either. The state employees 12 inspectors to monitor 2,468 mental health, mental retardation and substance abuse service locations, including group homes. That's an average caseload of 206 locations per inspector. A single inspector has responsibility for all of South Hampton Roads, except Portsmouth. Accidents and injuries are supposed to be self-reported by the provider, but may go unreported. Deaths do not have to be

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[5] See especially the report prepared by Robert Anthony, Ph.D. His report details the fallacy of the Commonwealth's expectations with regard to cost savings associated with training center closures and even exposes errors in the figures used by the Commonwealth to predict savings. Peer-reviewed, cost comparison research has found that cost savings are not likely to be realized when transitioning individuals with developmental disabilities from large, specialized settings to smaller settings, and points to recurring errors in past research which concluded savings (see, Kastner and Green, Cost Comparisons of Community and Institutional Residential Settings: Historical Review of Selected Research, Mental Retardation, Volume 41, Number 2, pp. 103-122 (April 2003; unpublished update, 2009)

[6] See generally, "Media coverage highlighting the increasing need for more effective federal and state protections in the ever-expanding community system of care for people with intellectual disabilities," VOR (rev. November 2011) (extensive bibliography of studies and media reports detail systemic problems associated with community-based care for people with ID/DD in more than half the states, including Virginia); *see also*, "In State Care, 1,200 Deaths and Few Answers," *New York Times*, November 5, 2011 (exposing 1,2000 "unknown and unnatural" deaths in group homes); Shavelle, Strauss, and Day, "Deinstitutionalization in California: Mortality of Persons with Developmental Disabilities after Transfer into Community Care, 1997-1999," Journal of Data Science 3 (2005) (finding that risk of morality was ---% higher in the community than in facilities); "More abuse, neglect reported in Illinois group homes," *The Associated Press*, May 20, 2011; "Neglected to Death," *The Miami Herald*, April 30 – May 4, 2011; "Oregon's safety net for vulnerable elderly in long-term care riddled with holes, *The Oregonian*, March 26, 2011 (Oregon closed all its ICFs/MR in 2010); "District Suspends Referrals To Nonprofit's Group Homes; City Took Agency to Court This Week Over Safety Concerns," Washington Post, October 9, 2009 (this is one in a series of dozens of articles detailing the plight of D.C.'s disabled, concerns which were first exposed in the Pulitzer-prize winning series by reporter Katherine Boo, "Invisible Deaths: The Fatal Neglect of D.C.'s Retarded" (December 1999).

reported to the medical examiner. State records that do exist show problems. (February 29, 2004).

Whether receiving care in a community group home or a state run residence[7], people with ID/DD deserve a safe environment staffed by competent caregivers who benefit from regular supervision by administrators who are accountable to government oversight – oversight which is sorely lacking in community-based settings. While the proposed settlement agreement contemplates an improved system of quality assurance, these are only paper assurances which are not supported by accurate cost assumptions.

Training Centers Are Inclusive, Most Integrated Settings For Residents

Despite the ideological bias perpetuated by DOJ in its Complaint, training center residents are part of their communities. As in Virginia, ICF/MR campuses around the country are used by their neighbors for summer camps, soccer practices, school gatherings, community events, and more.

This Court has received many letters from families of training center residents. VOR received copies of many of these same letters. They are poignant, and as a whole, speak to the true communities in which their family members receive life-sustaining services from tenured, compassionate staff and the independence residents enjoy within and outside the training center, including significant interaction with disabled and nondisabled friends:

> "Implicit in the language of the Settlement is that institutions -- i.e. Training Centers -- are confining, restrictive, lacking in stimulation for the residents, and not the best environment in which individuals with ID/DD can thrive. Conversely, 'community' is implied to be positive, integrated, open, less confining or restrictive, and the environment where all individuals with ID/DD can live and function best. This is a false premise, and it is simply wrong to depict 'institutions' and 'community' as polar opposites, with one being inherently bad and the other inherently good for individuals with ID/DD. . . . I have volunteered at many on-campus functions that allow the NVTC residents to thrive, be stimulated, and be happy in their 'institutional' setting: NVTC routinely hosts parties, dances, concerts by local musical groups, performances by magicians, hayrides in the fall, ice cream socials, coffee houses, etc. I have also volunteered to take NVTC residents to many off-campus events: picnics, trips to Burke

[7] VOR is aware that the Virginia Office of Protection and Advocacy (VOPA) submitted comments to this Court which, according to the *Times-Dispatch*, "catalog of alleged abuses suffered by patients at state training centers" (April 4, 2012). Notably, DOJ, in its final complaint, did not allege improper conditions at any of Virginia's training centers. As licensed ICFs/MR, all allegations of abuse at training centers must be reported. There are no comparable reporting requirements in community settings. Very often, community residents suffer from "out of sight, out of mind" situations. We expect that even VOPA does not track community abuse, or even could for lack of any central reporting mechanism. These comments by VOPA are suspect. VOPA's organizational policies support closing training centers and routinely ignore personal choice (see e.g., *Arc of Virginia v. Kaine* (December 2009) ("Thus, the argument made by Arc and the United States who filed regarding the risk of institutionalization fails to account for a key principle in the Olmstead decision: personal choice") (VOPA was counsel to The Arc of Virginia).

> Lake Park, Washington Nationals baseball games, Potomac Nationals baseball games, Washington Bullets games (before they were the Wizards), George Mason University basketball games, outdoor concerts at the Jefferson Memorial, the National Christmas Tree, and many other stimulating off-campus events." (Roger Hartman, Letter to Judge Gibney, February 22, 2012).
>
> "I am always surprised to hear people who do not know any better say that these individuals don't have a life in the community. Let me tell you about Chris's community life. Chris works at a sheltered workshop off the premises, Monday through Friday. He goes to the mall, to lunch and dinner, the movies, Wolf Trap Amphitheater (he has been there more than I), sports games, local fairs, Constitution Hall, the aquarium, Special Olympics, therapeutic riding, Easter Seals camp, swimming twice a week, formal dances, the circus, and Church. I would say he is a pretty active guy." (Linda Currington, Letter to Judge Gibney, February 12, 2012).

Likewise, the typical notions of what constitutes "community living" do not always equate to reality. Consider Chris Currington's experience:

> Chris has Lennox Gasteau Syndrome (many different types of seizure with unknown cause), a degenerative brain disease, osteoporosis, and mental retardation. The group home was no match for Chris's medical needs. He was assigned to that group home and lived there for 1½ years. During that time, Chris had constant status seizures, constant urinary tract infections, an unexplained black eye, an unexplained broken finger, and a huge weight loss. During the 1½ years in the group home, the majority of time was spent at Fairfax Hospital, where doctors worked hard to stabilize Chris's seizures and constant infections. Every time Chris would go back to the group home, he would seize constantly and become sick. [Before his admission to Northern Virginia Training Center,] Chris and I lived at Fairfax Hospital. (Id.)

Just this week, the *Washington Times* provided a glimpse of what "community integration" means for people with mental illness:

> "A 22-year-old Virginia man who had been living in a group home was brought to an emergency room on July 18. He had been biting staff, pouring antifreeze, motor oil and cleaning fluid on himself and running into traffic. Voices were telling him to harm himself. Facilities declining to temporarily detain mentally ill people because of capacity or service issues — also known as "streeting" — is a growing problem in Virginia, as the state grapples with how to properly provide for individuals with severe mental illness . . .
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> The issue surfaced in a report from the office of the inspector general (OIG) for the Department of Behavioral Health and Developmental Services, which said 200 such people were turned down from April 1, 2010, through March 31, 2011. . .
>
> The state and the federal government recently reached a $2.1 billion settlement that would close four of Virginia's five "training centers" for people with intellectual and developmental disabilities over the next 10 years. ("'Streeting' of mental illness patients

a problem in Virginia; Hospitals lack detainment beds," *Washington Times*, April 2, 2012; http://www.washingtontimes.com/news/2012/apr/2/streeting-of-mental-illness-patients-a-problem-in-/print/).

Nothing in these letters from the families resemble the stark, segregated, ideologically-biased picture of an "institution" painted by DOJ in its Complaint. As noted above, families – not DOJ attorneys or Virginia officials – visit their family members regularly and provide unmatched oversight with the well-being of their family members being their only motive.

People On The Waiting List Will Continue To Wait and Suffer; Community-Based Residents Who Now Benefit from Training Center Professional Supports Will Go Without

VOR supports the expansion of community-based services for Virginians with ID/DD. A waiting list of 7,000 speaks directly to the need for expanded options. VOR submits, however, deinstitutionalization and unrealized cost savings have contributed to a growing waiting list in nearly every state.

Nationally, there are more than 115,000 people with ID/DD waiting for residential services.[8] In Virginia, capacity would have to increase by 57.6% to meet the needs of individuals waiting for residential care.[9] As stated by one provider of community-based services in Virginia:

> As a provider of residential services, one of our Company's concerns in shutting down the Training Centers is that there has been no definitive decision to increase the rates for community based waiver slots. Currently the State is proposing that most Training Center individuals should be served in 4 bed facilities. The reality is, we have been successful in working with intensive behavioral and medical needs because we do not seek to operate 4 bed facilities. I would also like to add that for 3 years now, have maintained waiting lists for up to 6 to 12 months for placements. Good Neighbor Homes has also within the past year, taken over the operations of Hanover County's three group homes. Under the County's operations of them all being operated as 4 bed facilities, and this is also public knowledge, the County was losing around $400,000 a year and had been for many years. In assuming the operations of these homes, we immediately increased the capacity to all three locations by replacing one and appropriately adding extra bedrooms to the other homes. . . . I would also like to comment on the fact that their proposal to increase rates for only 4-bed facilities, is biased to a system that has not proven to work for intensive behavioral and medical needs in Virginia and will continue to be underfunded even with a 20% to 25% increase. (Matthew Marek, Executive Director, Good Neighbor Homes, Inc., Letter to Judge Gibney, March 2012)

[8] Residential Services for Persons with Developmental Disabilities: Status and Trends Through 2010,"Research and Training Center on Community Living Institute on Community Integration/UCEDD, College of Education and Human Development University of Minnesota (2012) (http://rtc.umn.edu/docs/risp2010.pdf).
[9] Id.

In addition to more people waiting and longer waits, closing training centers will also mean that clients of the Regional Community Support Centers (RCSCs) at Virginia's Training Centers will suffer. RSCSs help ensure a truly integrated and successful community experience for nonresidents. RCSCs provide services to individuals in the community who would otherwise be underserved or not served due to inability to access services for various reasons. Training center staff provide specialized, out-patient health and behavioral services that are not readily available in the community, including dentistry, primary care, psychiatry, behavioral consultation and other clinical specialists, as well as training to community-based staff. College student internships, externships and practicum are also offered. The outreach and impact is remarkable:

RCSC Five Year Service Report
FY 2006 -2010

- Number of Clients = 627 (unduplicated)
- Number of Clinical Visits = 11,327
- Total Hours of Service = 11,588

Most Frequently Requested Services
- Dental
- Therapeutic Recreation
- Nursing
- Psychiatry

RCSC Five Year Service Report
FY 2006 -2010

- # of Community Staff Trained = 289
- Hours of Training Provided = 1,027
- # of Student intern/extern/practicum = 376
- # of Colleges and Universities = Average of 25 per year

Source: Mark Diorio, Ph.D., Director, Northern Virginia Training Center, Presentation to the Senate Finance Committee, December 5, 2011)

Conclusion

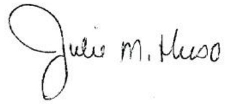
VOR urges this Court to reject the proposed settlement agreement as written.

As detailed above, the proposed agreement unfairly impacts and potentially harms training center residents, the most vulnerable of Virginia's citizens with disabilities, who were not consulted or provided information as to the specific provisions which directly impact their rights as provided by Americans with Disabilities Act (ADA) / *Olmstead*, Medicaid and state law. Lessons learned in other states, coupled with the Commonwealth's faulty cost savings expectations, make tragedies predictable if the settlement is approved and closures implemented.

VOR respectfully asks this Court to reject the proposed settlement either outright or with correcting amendments. For more information please contact Tamie Hopp, VOR's Director of Government Relations & Advocacy at 605-399-1624 or thopp@vor.net.

Thank you in advance for this opportunity to submit comments. We appreciate your thoughtful consideration. There is much at stake for all Virginians with intellectual and developmental disabilities and their families.

Sincerely,



Julie Huso
Executive Director