

**COMMUNITY RESIDENCES INC.  
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TESTIMONY TO THE CONNECTICUT GENERAL ASSEMBLY  
APPROPRIATIONS COMMITTEE

**Public Hearing on the Governor's Proposed Deficit Mitigation Plan and the Impact of the  
Governor's Rescissions on Human Services Programs**

Co-Chairperson Harp, Co-Chairperson Geragosian, members of the committee, thank you for the opportunity to provide testimony. My Name is Paul M. Rosin and I am the Executive Director of Community Residences Inc. a not-for-profit multi-service provider of day, residential, and family support to children and adults with special needs. I am also a member of the Connecticut Association for Non-Profits Legislative Committee.

I am here today to speak against the Governors proposed deficit mitigation plan that will cut \$14,430,000 out of the budget for Nursing Homes and Intermediate Care-Mental Retardation (ICF-MR) in SFY10.

In early 1972, Geraldo Rivera, then an investigative reporter for ABC News in New York City, conducted a series of investigations at the Willowbrook State Hospital on Staten Island, uncovering a host of deplorable conditions, including overcrowding, inadequate sanitary facilities, lack of services and physical and sexual abuse of developmentally disabled residents at the facility. Soon after this, names such as Pennhurst (PA), Belchertown (MA), Mansfield Training School (CT), and Southbury Training School (CT) became familiar to politicians, human services professionals and ordinary citizens. In response to these and many other horror stories, the U.S. Federal Government established the ICF-MR program for people with developmental disabilities, utilizing Medicaid (Title 19) funding. What was unique about this program was that it established, for the first time, quality standards that the States needed to meet in order to get funding. The result over the past 30 years has been remarkable and positive for citizens who are developmentally disabled and need to be supported outside of their homes.

CRI operates ten (10) ICF-MR group homes under contract with the Department of Social Services (DSS). The residents in these ten homes are severely to profoundly developmentally challenged and need intensive supports 24-hours per day. Four of the homes have 24-hour nursing due to the complexity of their medical needs. I can tell you with every confidence that if I had a brother, sister, son, or daughter who was developmentally disabled and needed 24-hour care, I would have no problem placing them in one of these homes. Due to the Licensing standards and funding made available through T19, the homes are attractive, appropriately staffed, supported by the necessary clinical professionals, supervised, and clearly meet the needs to the residents placed there by the State.

The Governor's November 24<sup>th</sup> deficit mitigation plan is proposing what we calculate to be, at a minimum, a 4% cut in funding from now through June 30, 2010. Given that ICF-MR Programs are no longer reimbursed for vacancies, this will equate to a 5% cut or \$500,000. With 10 ICF-MR Programs this would average \$50,000 per program to be absorbed between now and June 30<sup>th</sup>. I have attached to my testimony the programmatic impact of these cuts. Suffice it to say four things will happen if the cuts occur:

- Instead of having institutional-based custodial care Connecticut will have community-based custodial care.
- With Dramatic cuts in direct care, health services and middle management supervision, the programs will not be able to meet the Federal CMS quality indicators and as a result, the programs will be de-certified.
- De-certifications will stop T19 reimbursements which provide up to \$5 million/year of funding to CRI's ten (10) ICF-MR Programs. Multiply that out over the 50 plus not-for-profit ICFs in the State and it is very significant revenues.
- Instead of high quality, needs based, normalized, consumer driven services, residents will be fed, changed, hopefully protected from harm.

Given the fact that group homes typically have 4-6 beds, any decrease in staffing will be significant. In order to provide active treatment (*defined as providing targeted, intensive and consistent services designed to remediate developmental deficits and the key ICF-MR Licensing regulation*) to significantly developmentally challenged individuals you need a staffing ratio of **1 staff: 2.0-2.5 consumers**. The Governor's proposed budget cuts

would necessitate a staffing ratio of **1:3**. The bottom line is with a 1:3 staffing ratio there will be no active treatment, with no active treatment no certification, no certification no Federal reimbursement.

Generally speaking, we as human services professionals do not have visual or auditory deficiencies. We fully appreciate the fact that the Legislature and the Governor have a huge hole to fill. With all due respect hitting programs that support our most vulnerable and challenged citizens with a 5% budget cut is not the way to go. I would suggest that you give to the human services providers the same respectful opportunity you gave the towns and cities to make recommendations on ways to find money. Let us work together on this problem. Cutting 5% from ICF-MR program will save the State some money in the short term but it will surely cost you many times over in the long term.

Paul M. Rosin  
Executive Director  
Community Residences Inc.  
December 7, 2009

## Programmatic Impact of 5% Revenue Reduction

**Coordinator Reduction-** The reduction of one QMRP position increases case load of remaining Coordinators. Currently there are 3 Coordinator positions in the ICF's. Coordinator 1 has 24 ICF beds and a day program of 15. Coordinator 2 has 14 ICF beds and 2 day programs totaling 55 people. Coordinator 3 has 16 ICF beds and 1 day program totaling 47 people.

Possible Reorganization may include:

### Option 1

- Reduction of Coordinator 2 with the least ICF beds.
- Increase Coordinator 3 to 22 Beds
- Both ICF Program Directors would need to directly supervise and be the QMRP for a 4-bed ICF. One Program Director would also need to directly supervise 2 day programs of 55 people in addition to the 4-bed ICF.

### Option 2

- Reduction of Coordinator 2 with least ICF beds
- Increase Coordinator 1 to 28 beds (5 ICF's) and 1 15 person day program
- Increase Coordinator 3 to 26 beds (5 ICF's) and 1 47 person day program
- One Program Director assumes direct responsibility for 2 day programs 55 people

### Option 3

- Reduction of Coordinator 2 with least ICF beds
- Increase Coordinator 1 to 28 beds (5 ICF's) and 2 day programs totaling 48 people
- Increase Coordinator 3 to 26 beds (5 ICF's) and 2 day programs totaling 69 people

The more beds a QMRP has less time and attention can be paid to the details of the records. This will increase licensing deficiencies and reduce thoroughness.

In options 2 and 3 the Coordinators would have 5 homes and day programs each reducing time spent in oversight of each program. Will result in less coordination, less support to managers and likely active treatment deficiencies.

**Reduction of 399 Direct Support Hours-** In this scenario each of the 10 ICF's runs at a minimum safe staffing pattern. It includes 2 staff in the AM, 2.5 staff on second shift in the 6 beds and 2 staff on third shift.

Two staff in the morning will make it exceedingly difficult, if not impossible to get residents to day programs on time. In the 6-bed programs (LP, FA, RO and HH) two

staff will need to bathe, dress, feed and do meds for 6 people. This will result in custodial care where there is barely enough time for essentials and no time for active treatment, programming, incidental teaching or quality interactions. Active treatment deficiencies will occur.

With 2.5 staff on second shift medical appointments can be attended, however no leisure/community outings could be done. Staff would need to bathe individuals early, do dinner and pass meds prior to the 3<sup>rd</sup> staff leaving resulting in custodial care. There will be no time for active treatment, programming, incidental teaching or quality interactions. Active treatment deficiencies will occur.

On weekends in all 6 bed programs the 2:2:2 scenarios would eliminate any and all community outings.

**Reduction of 351.50 Direct Support Hours** –In this scenario the third morning staff is added back into the 6 bed programs Monday through Friday. This would increase the likelihood that clients could get essential services and arrive to day program on time. The second shift and weekends remain the same as above with active treatment deficiencies likely.

**Reduction of 54 LPN Hours-** The reduction of these hours comes from 3 ICF's. The 16 hours from Erica Lane are being removed anyway as schedule adjustments were already under way. The full time LPN would be removed from FA completely. The impact can be increased med errors, increased need for LPN Coordinator and RN to spend more hours in the home. The remaining LPN hours would be cut from Lydale. The M-F am nurse would be removed and one FT LPN on 2<sup>nd</sup> shift would be removed, leaving an LPN M-F second shift. The LPN's were added due to client SS medical issues primarily. He no longer lives there. Other clients have increasing medical needs; however none currently require a nurse. These residents have a significant amount of medications and approximately 10 med passes per day. Reduction in nursing will result in increased medication errors in the home and increased time of LPN Coordinator and RN.

**Day Program Reductions-** the reduction of the floater staff will have little impact on the day program assuming enough substitute staff can be available to cover staff PTO time.

**Kevin did 4 scenarios combining different reduction options above.**

**Scenario 1** cuts 399 DC hours and the Coordinator. This is the most drastic scenario and will result in both programmatic licensing deficiencies and active treatment deficiencies. Worst case programs begin to get decertified.

**Scenario 2** cuts 399 DC hours but maintains the Coordinator position. Again active treatment deficiencies and potential decertification.

**Scenario 3** cuts 351.50 DC hours and cuts the Coordinator. Better chance of an active treatment call, however less supervision and support of manager, increased licensing deficiencies in records.

**Scenario 4** cuts 351.50 DC and keeps the Coordinator position. This scenario is the least intrusive and offers the best chance to maintain some level of quality while meeting all the needs of the clients. It is also the scenario that leaves the largest budget deficit to the agency.

It may be possible to take scenario 4 and make some adjustments to all 3 Coordinators hours adjusting to 32 instead of 40 to mitigate that deficit.