



**SEIU**Healthcare®  
United for Quality Care

Testimony of Deborah Chernoff, Public Policy Director  
New England Health Care Employees Union, District 1199, SEIU  
Before the Appropriations Committee

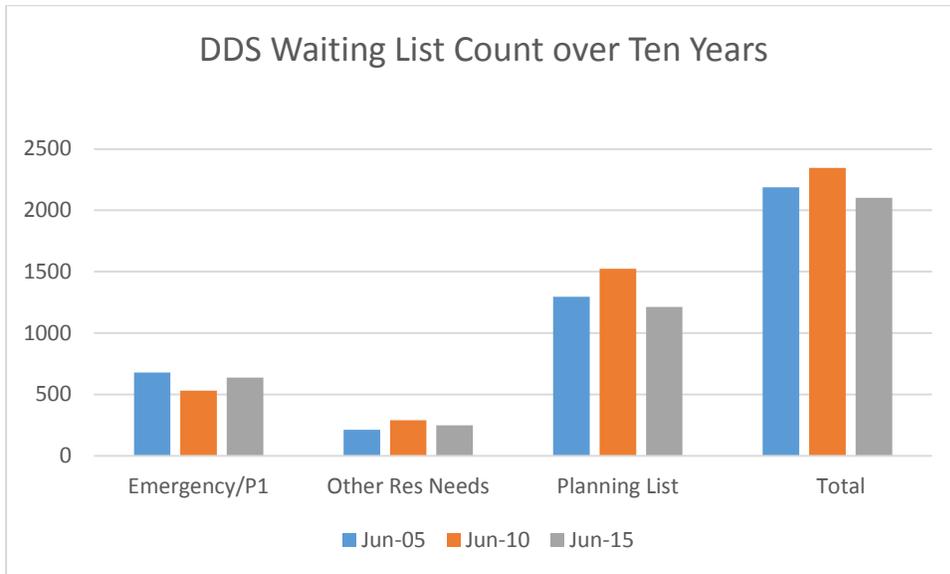
*Re: Mid-term Budget Adjustments for Health and Hospitals*

Good afternoon, Senator Bye, Representative Walker and members of the Appropriations Committee. For the record, my name is Deborah Chernoff and I serve as Public Policy Director for District 1199; our union represents close to 20,000 professional and direct-care workers in both the public and private sector who provide health care services and supports.

The budgets adjustments you are considering today deprive these dedicated professionals and caregivers of the resources necessary to keep Connecticut citizens living safe, healthy, productive lives in the settings and communities of their choices. \$73 million in across-the-board cuts, plus millions more in cuts to targeted programs in the Departments of Developmental Services, Mental Health and Addiction, Public Health, Veteran's Affairs and the Office of the Chief Medical Examiner, put our most vulnerable citizens at further risk.

For just one specific example, DDS already lacks the resources to meet the current needs of thousands of families; cutting an additional \$32 million across the board will only exacerbate that deficiency. Between June 2005 and June 2015, the number of families with some level of unmet need has hardly budged (see chart on next page below). None of the budget adjustments create a single additional hour of support or service for even one individual, let alone the 2,000 plus on the line that never moves.

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The Governor’s Budget projects savings in excess of \$6 million annually by converting 30 public Community Living Arrangements to private operation. It’s impossible to quantify the human cost of breaking up the families that our state caregivers have formed with the people they care for, but I **can** tell you that, based on the RFP that has already been posted for seven public CLAs, every penny of the projected savings comes from one fact: paying different caregivers far less money for providing the same kinds of services. Forget the ostensible private-sector “efficiencies” or benefits package. The state expects to save 38% of the annual cost of operating these residences (see chart on the next page, below). The differential for hourly wages alone between DDS’ average for typical direct-care workers in the private sector and the public sector is also 38%.

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FY 2015 Expenditures					
Department	Total DDS Expenditure	Proposed Maximum Budget for Private Provider	Proposed Annual Cost Savings	Percent annual savings	
DDS51073 N PS RS 96 FarmgtnAv Frmgtn	\$749,688	\$ 471,296	\$ 278,392	37%	
DDS51074 N PS RS 100 FlaglerStNewington	\$646,751	\$ 637,708	\$ 9,043	1%	
DDS51095 N PS RS 185 PineSt Mnchstr	\$509,865	\$ 468,051	\$ 41,814	8%	
DDS51123 N PS RS Waterford Common #111*	\$1,249,447	\$ 412,632	\$ 836,815	67%	
DDS52136 S PS RS 100 Lowe Ave Meriden	\$569,562	\$ 272,658	\$ 296,904	52%	
DDS52138 S PS RS 62 Summit Woods Norwch	\$341,459	\$ 248,222	\$ 93,237	27%	
	\$4,066,772	\$ 2,510,567	\$ 1,556,205	38%	
*Two CLAs at one location					
<b>Direct-Care Residential Workers</b>	<b>Hourly wage*</b>	<b>\$ difference</b>	<b>% difference</b>		
State of Conn - Year 4	\$ 23.56				
Lower wage private non-profit - Year 4	\$ 12.34	\$ 11.22	48%		
Higher-wage private non-profit - Year 4	\$ 16.31	\$ 7.25	31%		
DDS-calculated state average wage	\$ 14.65	\$ 8.91	38%		

\*Source: Collective Bargaining Agreements, State of Connecticut, HARC, CIB/Oak Hill with District 1199 SEIU

We lack the data to determine whether these are even real cost savings, or if they represent cost-shifting instead. We don't know how many private-sector workers rely on Medicaid, food stamps and other state assistance because their wages are inadequate. You have heard from non-profit providers about their difficulties in recruiting and retention and the high costs of turnover that originate in decades of under-funding. Numerous academic studies<sup>i</sup> also note that privatization erodes middle-class jobs, thus eroding the tax base and revenues whose shortfall are the root cause of this state's budget deficiencies. Those 30 homes employ more than 500 direct care workers; eroding the quality of 500 middle-class jobs will keep us spinning in the same vicious circle to no one's benefit.

Our members have a different vision that begins with identifying the unmet needs of the ID/DD community and using the skills, experience and training of current state employees to meet those needs. As we evolve to more home-and-community-based services, this state has an opportunity to fill in the numerous service gaps by deploying DDS professionals and paraprofessionals in new and

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expanded roles without expending new dollars. I have attached a detailed list of some of our ideas on how to do that to this testimony.

The “new budget reality” is upon us and we acknowledge it. But we must also acknowledge the real damage that this budget inflicts on these already-wounded state agencies and seek real solutions that don’t simply shift costs or do more long-term damage to our economy.

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<sup>i</sup> See one recent example at <http://www.uccs.edu/Documents/ccps/2014/contracts-broaderimpacts-greenwood-march-2014-REVISED-AND-FINAL.pdf>.

*Attachment to testimony – submitted to DDS previously:*

*Re: Mid-term Budget Adjustments for Health and Hospitals*



Date: Friday, December 4, 2015  
To: Commissioner Morna Murray, DDS  
From: Deborah Chernoff  
Public Policy Director  
New England Health Care Employees Union, District 1199, SEIU

Our union represents all of the professional and paraprofessional workers in the Department of Developmental Services, including those at the Southbury Training School so we are, both by definition and inclination, DDS stakeholders. We also have particularly relevant experience with the significant and successful transition in the model of care for DDS clients that came with the closure of the Mansfield Training School in 1993, when our DDS members followed the clients into the community.

As the model of care and best practices in the delivery of services for people with ID/DD continues to evolve, our members want to help shape a system that meets the growing and changing needs of this community.

### Vision and Fundamental Principles: Fulfilling the DDS Mission Statement Requires a Robust Public-Private partnership

Connecticut must maintain, reinforce and expand the spectrum of services across the public and private sectors, recognizing and drawing on the particular strengths of both sectors to enhance services to clients and families, in order to fulfill the DDS Mission Statement.

*Developing and balancing the public/private partnership that currently exists in Connecticut is the only way to meet the growing – and changing – needs of the people with ID/DD. The public sector has the size, breadth of experience, range of skills and geographic reach to cover the broadest range of needs and can supplement the provision of home-and-community services by individuals and private provider agencies. The public sector can also innovate and pilot programs and models that might work well in the private sector once their efficacy is demonstrated.*

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Concept for Change: Identify unmet needs of ID/DD community. Utilize skills, experience and training of current and future STS (and other DDS) employees to meet those needs across the public/private spectrum of services.

As the census continues to shrink at STS and the DDS care delivery model evolves, Connecticut has an opportunity to fill in the numerous gaps in ID/DD services in both the public and the private sector by deploying DDS professionals and paraprofessionals in new and/or expanded roles.

*Suggestion One: Provide behavioral supports to help keep families together and serve people with significant disabilities at home/in the community.*

**Justification:** As the public outcry over the budget cuts to Behavioral Services indicates, behavioral supports that enable children and adolescents to remain in the family home are already insufficient. For families with adult members with ID/DD, behavioral supports and services can diminish or even eradicate the need for eventual residential placement and expand choices when family caregivers are no longer able to support their adult children or siblings.

STS workers (and DDS employees at the Regional Centers and state-operated group homes) have experience with a wide range of behavioral issues in this population and could be deployed to family homes to teach and model effective behavioral management. For some families, this would need to be an ongoing service which could reduce out-of-state placements for youth and adolescents who cannot be effectively served in CT. For other families it would provide transitional support as family circumstances and resources or the needs of the DDS client change.

The initial DDS pilot program to send STS workers out to provide Individual and Family Supports (IFS) services was successful in training 38 DDS employees to provide these Home- and Community-Based services but less successful in actually deploying those workers; only three are currently providing IFS services. The discrepancy between workers trained and workers deployed should be examined and explained and the protocols corrected to take advantage of these untapped resources.

*Suggestion Two: DDS employees have the professional skills and experience with the ID/DD community to provide quality health care services without requiring additional training in how to work with this population. The ID/DD community that relies on either Medicaid or DDS funding for community medical and dental services is woefully underserved. Many community medical providers lack the experience with this population to provide effective treatment*

**Justification:** DDS currently employs Occupational Therapists, Speech Therapists, Physical Therapists, nurses, physicians, dentists and dental technicians, all with expertise in working with DDS clients as well as professional skills. With the difficulties in recruiting and retention in the private sector after years of insufficient funding, there are shortages in the private sector and community health settings for professionals with this kind of experience and training. Many providers also remain unwilling or unable to accept Medicaid as payment for services.

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DDS employees should become part of the team providing services in the home for individuals receiving In-Home or Family Supports. DDS nurses, physicians and social workers should also provide women's health care/reproductive education, supports and services both in group or family homes.

While some private providers do offer some or all of services, the deployment of DDS employees to provide these professional services in the private sector would free up funding for direct care workers in private sector residential, day service and employment settings and restore the hours and staff cuts that have been the result of multiple years with no COLAs for this sector.

These types of services could also be provided regionally at Southbury and the current Regional Centers by appointment or as walk-in clinics for individuals living in the community as an alternative to seeking out local physicians, dentists and other medical providers, where waits for appointments can be very long due to the scarcity of experienced professionals who will accept Medicaid as payment.

*Suggestion Three: Expand the availability of DDS Respite Services*

**Justification:** Respite services are inadequate to meet the needs of thousands of families who are providing care at home. Families need more frequent access multiple times during the year, the length of the typical planned respite stay has decreased and unanticipated/emergency needs are difficult to meet.

State DDS workers from STS and other settings in transition can provide more frequent opportunities (multiple occasions during the year) and longer periods of respite (to accommodate a family vacation or the temporary incapacity of a caregiver). State caregivers would have the flexibility to respond swiftly to an unplanned need for respite. The state's stable workforce means families can be assured of a team familiar with individual needs and concerns; the state already has the physical facilities and geographic spread to meet needs in most areas of the state.

The expansion of respite services in the manner would reduce the extreme stress of unpaid family caregiving and potentially reduce the demand for residential services by giving families sufficient release to delay their need for costly and limited residential placements.

*Suggestion Four: Reduce the number of individuals with ID/DD residing in nursing homes or incarcerated by deploying DDS workers to provide appropriate services in home or community settings.*

**Justification:** Currently there are at least 46 DDS clients who are incarcerated and 343 residing in skilled nursing homes, based on the June 2015 Management Information Report. Nursing home and corrections staff do not have the special training or experience to provide services to individuals with ID/DD. DDS should explore using current DDS facilities to establish specialty group homes to provide services to the elderly and forensic populations within the ID/DD community. This would be the humane, mission-compliant course of action; it is also likely to reduce the cost of placing these individuals in settings that are inappropriate for providing supports for their particular disabilities. For example, one or more cottages on the Southbury campus could easily be transformed into small skilled

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nursing centers for older individuals with ID/DD that would fit the “greenhouse” model for smaller, more home-like nursing facilities; Southbury already has the nursing and medical staff that would be needed to support and care for this population.

*Suggestion Five: DDS workers should pilot new models of residential services less institutional than the traditional group home*

**Justification:** The state has the human and financial resources to create pilot programs that can test and model new ideas about residential services that are more consistent with focus on increased community integration and individual self-direction and choice while providing more supports than the current CTH or Supported Living models. Many advocates have suggested smaller, two- or three-person group living arrangements that would be difficult and expensive for all but the largest private agencies to purchase or construct. This model also needs to be tested for effectiveness, adequacy, safety, and viability, tasks best accomplished with a trained, stable staff and the public resources of DDS.

*Suggestion Six: DDS workers can expand opportunities for truly meaningful therapeutic and age-appropriate recreation in day programs in both the public and the private sector.*

**Justification:** In too many Day Programs, recreational activities are neither therapeutic nor integrative. Trips to the mall are not therapy; dances and other social activities do not offer opportunities to interact with the broader community. More meaningful activities, including sports and fitness, require sufficient training, skills and staffing but current constraints on funding to private providers has limited their ability to provide recreational and social activities that are truly therapeutic. These services could be provided and/or supplemented in both state-operated and private Day Programs by STS and other DDS employees.

Fitness, wellness and stress management programs could be integrated with the provision of health services as outlined in Suggestion Two above and designed to meet the needs of participants of all ages, with particular emphasis on the current aging and/or nursing home population (Suggestion Four).