

August 8, 2025



Hiram Davis Medical Center (HDMC)
Planning Team
Community Services Subcommittee

State Fiscal Year 2026

HDMC Planning Team – Community Services Subcommittee

I. Executive Summary

The HDMC Planning Team Community Services Subcommittee, formed under *Virginia Code § 37.2-316*, was tasked with recommending community-based services to ensure equitable care for those served by HDMC. The team, comprised of representatives from HDMC, DBHDS, CSBs, family advocates, legislators, providers, and legal groups met monthly to assess:

- Populations served by HDMC: ID/DD, SMI, and SVP
- Reasons individuals rely on HDMC vs. community services
- Existing service levels and unmet needs statewide

They identified service gaps for all three populations and proposed expanding the community continuum of care, acknowledging a multi-year transition is needed. During this development, HDMC should remain open as a safety net and evolve into a Virginia Center for Integrated Care to retain institutional knowledge.

Given structural concerns, the committee suggests repurposing existing Petersburg campus buildings for support functions and building a smaller residential/patient facility. These changes aim to improve health outcomes, especially for aging and underserved individuals supported by DBHDS.

II. Subcommittee Scope and Objectives

Virginia Code § 37.2-316 requires a state and community consensus planning team be established for the purpose of considering any restructuring of the system of mental health services involving a state hospital. The team should consist of DBHDS staff and representatives of the localities served by the state hospital, including local government officials, individuals receiving services, family members of individuals receiving services, advocates, state hospital employees, community services boards, behavioral health authorities, public and private service providers, licensed hospitals, local health department staff, local social services department staff, sheriffs' office staff, area agencies on aging, and other interested persons. In addition, the members of the House of Delegates and the Senate representing the localities served by the affected state hospital may serve on the state and community consensus and planning team for that state hospital. The Community Services Subcommittee has the responsibilities to develop, in collaboration with the Commissioner, a plan that addresses:

1. The types, amounts, and locations of new and expanded community services that would be needed to successfully implement the closure or conversion of the state hospital to

any use other than the provision of mental health services, including a six-year projection of the need for inpatient psychiatric beds and related community mental health services

2. The development of a detailed implementation plan designed to build community mental health infrastructure for current and future capacity needs
3. The creation of new and enhanced community services prior to the closure of the state hospital or its conversion to any use other than the provision of mental health services
4. A plan for community education
5. A plan for the implementation of required community services, including state-of-the-art practice models and any models required to meet the unique characteristics of the area to be served, which may include models for rural areas
6. A plan for assuring the availability of adequate staff in the affected communities, including specific strategies for transferring qualified state hospital employees to community services

In considering the proposal of closure of HDMC, it was necessary to explore the community needs of individuals with intellectual and/or developmental disabilities (ID/DD), severe mental illness (SMI), and/or a label of a sexually violent predator (SVP). The committee also examined the three levels of care provided at HDMC, General Medical/ Acute Care, Skilled Nursing Care, and Nursing Facility Care, and how HDMC uniquely provides a safety net for these populations when community needs are not met. HDMC has accepted admissions for these services from all areas of the state due to the unavailability of services or poor quality of services.

The Community Services Subcommittee consisted of:

Membership

- Amy Loving, BA, QDDP, Former CSB Support Coordination Supervisor
- Angela Taylor, Family Member/Legal Guardian
- Heather Fisher, RN, BSN, MPA SEVTC Chief Executive Officer
- Dr. Amy Handley, PhD, CSH Chief Clinical Officer
- Dr. Brianna Moore, PsyD, CSOTP, VCBR Director of Forensic Services
- Elsie Coleman, Crater Area District on Aging
- Demetrie Morton, COTA, HDMC Occupational Therapy Department Manager
- Dr. Atul Gupta, Family Member/Legal Guardian

DBHDS Co-Chairs

- Eric Williams, MSW, Acting Assistant Commissioner for Developmental Services

- Susan Moon, BS, RN, Director of the Office of Integrated Health Support Network
- Susan Alabanza, MS, OT, HDMC Chief Clinical Officer

III. Methodology

The Community Services Subcommittee met monthly with an extensive group of stakeholders. These stakeholders included the Disability Law Center of Virginia, Human Rights Advocates, family members, Virginia Department of Health, HDMC staff, and individuals receiving services at HDMC.

The key goals of the group were to determine:

- The types of services needed in the community for the populations that HDMC serves
- The gaps in community services
- How services can be created within the community to meet these needs in the same manner HDMC does

Subject Matter Experts presented on the following:

- PASRR process for adults and children
- Barriers to the use of CVTC
- How estimates developed for a new HDMC and a renovated HDMC
- State of the State of Developmental Services
- Workforce Challenges in Virginia – current and projected
- HDMC admissions, populations, and utilization
- VCBR data and discharge challenges
- DOJ related to ADA and Olmstead and National Nursing Home Initiative
- VDH re: Nursing Facility oversight and inspections
- Children with ID/DD in ICFs

Other topics covered during meetings included:

- Availability of Services along the continuum for each population
- Gaps in Service along the continuum
- How HDMC is different than community nursing facilities
- How HDMC is currently serving the community and how those needs are not often met or met with the same comprehensiveness in the community
- Definitions of skilled care across the continuum
- Partnerships between DBHDS and community providers for individuals with SMI diagnoses, sex offender registry, and/or SVP label
- Reimbursement currently for HDMC

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- Potential increase in reimbursement for HDMC
- Losing all reimbursement potential of ancillary services when they become part of CSH
- Research of any nationwide programs that address community services for individuals with ID/DD, SMI, and SVP

During the meetings, several recurrent themes were discussed. These included:

- Limitations in complex medical care in community-based services
- Increasing the services across the continuum for all populations served by HDMC across the state
- Maintaining the safety net that HDMC provides
- Quality of Care
- Workforce challenges
- Fears of federal /state funding

Stakeholders voiced serious concerns about community services, including:

- Subpar care in nursing facilities
- Delayed inspections and weak regulatory oversight
- Loss of experienced staff, reducing capacity to support specialized populations
- Poor discharge protections, with group homes releasing individuals after medical decline
- Limited provider knowledge, particularly for complex needs
- Access barriers tied to diagnoses, payor source, labeling, and perceived lack of progress

These concerns emphasize the need for stronger safeguards, staff training, and accountability before transitioning individuals from HDMC to community settings.

Families expressed strong preference for HDMC to remain open on the Petersburg campus, citing its comprehensive wrap-around services, labs, radiology, dental, pharmacy, specialty clinics, and acute medical beds, as vital to consistent and timely care. HDMC staff's ability to collaborate virtually with interdisciplinary professionals ensures seamless treatment with familiar providers.

The Hiram Davis Center team brings deep expertise in providing complex care for individuals with IDD, particularly in:

- Nursing
- Speech Language Pathology
- Primary Care
- Occupational Therapy

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- Physical Therapy
- Dental Services

Compared to transitioning to skilled beds at SEVTC, family members favored HDMC's integrated approach and longstanding experience with DD populations.

The subcommittee and participants agreed that while most people select community-based services, expansion and improvements are needed across the continuum of community-based healthcare, a continuum that includes HDMC as a safety net.

Information collected and reviewed during subcommittee meetings informed the development of this report. Portions of the text were drafted with the assistance of Microsoft Copilot (accessed July–August 2025) and subsequently reviewed and approved by the authors.

IV. Findings

Unique and Specialized Care

Community members with complex developmental and behavioral health needs access specialized medical services through HDMC, bridging critical gaps left by broader systems. People with DD, SMI, or an SVP designation, particularly those experiencing co-occurring dementia, neurocognitive challenges, and medical decline, and/or acute medical needs, benefit from the coordinated care provided through HDMC. Community regulations require discharging individuals when their needs exceed provider abilities, but there are few safe options for referral. This often results in sudden transfers to hospitals or inappropriate settings, increasing emotional trauma and health risks. Group members see HDMC as the safety net when all else fails. It's considered a place people turn when the community system fails and without it, individuals with the highest vulnerabilities would be left without safe, specialized, and equitable care. Inpatient services at HDMC include General Medical/Acute Care, Skilled Nursing Facility (SNF) care, and Nursing Facility (NF) care - all certified by CMS and The Joint Commission. HDMC currently holds a five-star rating for its SNF and NF services.

- **General Medical/Acute Care** is comparable to hospital-level treatment and supports HDMC residents, DBHDS facility individuals, and adults with ID/DD from the community. Primary care physicians are available 24/7 across all levels of care.
- **Two types of skilled nursing services** are provided at HDMC. The first is the typical type of skilled care found in most nursing/rehab facilities that requires the skills of a nurse or a therapist with the expectation of an improvement in their condition. The second type of skilled nursing care is a long-term skilled nursing care that is typically not found in community nursing facilities. These residents can have more complex, chronic medical issues that need close monitoring for safety and health.
- **Nursing Facility or Long-Term level of care** is provided for individuals who have stable medical problems and are unable to take care of themselves or need assistance in daily care/ADLs. This level of care is typical in many community nursing facilities.

How HDMC Differs from Community Providers

Local health systems benefit from HDMC's in-house expertise, expanding access to services that are often unavailable or fragmented in traditional community settings. HDMC is certified as both a hospital and nursing facility, with services tailored to the unique needs of individuals with DD, SMI, and those determined to be an SVP, differing significantly from community providers with the same certifications. These individuals use HDMC for unresolved medical issues, declines in health, safety during Adult Protective Services (APS) cases, denials linked to stigmatizing labels, and end-of-life care. HDMC provides thorough evaluations when repeated ED visits, hospitalizations or outpatient care fail to resolve concerns.

HDMC enhances continuity of care by offering medical stabilization and interdisciplinary planning when community residential providers face limitations. Many community providers cannot accommodate behavioral complexity or co-occurring medical needs - leading to premature discharges and destabilization. Unlike community facilities, HDMC doesn't impose productivity standards or insurance limits for care, allowing individuals to progress at their own pace with healthcare professionals experienced in the treatment and management of complex physical and mental health conditions from admission to discharge and comprehensive follow – up. HDMC provides equal services to all, regardless of payor source, unlike community providers where insurance often limits access to services.

**Community Nursing Facility and HDMC Nursing Facility
Side by Side Comparison**

HDMC Skilled and Long-Term Care Beds	Community Skilled and Long-Term Care Beds
No productivity standards for therapy—residents receive what they need at their pace	Productivity standards for therapy – if the resident does not progress fast enough, therapy is discontinued
Specialized knowledge in working with individuals with DD, Behavioral Health, and SVP.	No specialized knowledge in working with individuals with DD, Behavioral Health, and SVP.
Permits admission of individuals with an SVP label with proper review and oversight.	Individuals with an SVP are rarely permitted in most facilities.
PCP onsite daily. PCP coverage 24 hours per day.	PCP coverage may take up to 60 days.
Medical Director serves only HDMC.	Medical Director may have oversight of up to 30 facilities.
Access to ancillary services in-house: • Respiratory therapy • Radiology • Laboratory • Dental (with anesthesia) • Clinics – Podiatry, OB/GYN, GI, Pre-surgical, Optometry	Access to ancillary services through mobile laboratory and radiology services or going to outside appointments
Access to Acute Care services in the same building with the same providers and staff	Transfer to a local hospital for acute care services
CNA training that teaches skills in working with DD, Behavioral Health, and SVP populations.	CNA training programs do not teach skills in working with DD, Behavioral Health, and SVP populations.
Extensive interdisciplinary discharge planning with post discharge follow-up.	Limited detail on essential supports and training for discharge planning. Follow-up may only be through MCOs.

While HDMC does not restrict care based on reimbursement or insurance status, its role within Virginia’s healthcare system includes seeking reimbursement where possible to sustain services. HDMC seeks reimbursement for many services and recognizes a significant potential to increase revenue. Currently, HDMC bills a daily rate that includes all services for inpatients and does not seek reimbursement for ancillary and outpatient services. This is currently an untapped area that could lead to increased revenue. Without HDMC’s status as a Medicare/Medicaid certified facility, DBHDS will not be able to collect revenue for any ancillary or outpatient services. Recent HDMC collections are listed below.

HDMC Overall Collections

Net Collections FY 2024	\$18,080,372.43
Net Collections FY 2025	\$17,871,580.00

Impact on Vulnerable Populations

Developmental Disabilities

- Across Virginia, individuals with developmental disabilities (DD) continue to face critical barriers in accessing comprehensive healthcare. These obstacles aren't isolated, as they stem from a complex mix of systemic challenges, geographic disparities, financial limitations, and social stigma. Many providers lack the training, resources, or infrastructure to offer person-centered care for individuals with DD, especially those with co-occurring conditions like dementia or medical fragility. Rural communities face even greater shortages of providers and accessible services, compounding the isolation and risks for people in need. These realities mean families often struggle to find appropriate care and when traditional services fail, HDMC serves as an essential safety net, ensuring that no one is left behind simply because their needs exceed what the community system can provide.
- Many healthcare professionals and most hospitals and primary care providers lack training in ID/DD-specific care, leading to misdiagnoses, inadequate communication and treatment, and poor patient experiences. (1)
- Individuals with ID/DD often face delays or denials in care due to behavioral complexities or stigmatizing labels, especially in emergency and end-of-life scenarios. (1)
- Rural areas have fewer services, longer travel times, and limited telehealth options. (1,3) Individuals with ID/DD may struggle to express symptoms or understand care plans, especially when providers lack adaptive communication tools. (1,2)
- Virginia ranks among the worst states for dental access for people with developmental disabilities. Medicaid offers limited adult dental coverage, and few providers accept patients with ID/DD. (1)
- Community based residential providers have narrow scopes of service. Discharge is required when the individual's needs surpass the provider's capacity or scope, ensuring the person is referred to a more appropriate level of care. (4)

- Regulations (12VAC35-105-693) (4) that ensure individuals receive care that matches their clinical needs and protects them from being underserved but this can lead to individuals being sent to hospitals and discharged from their home due to a lack of skills, resources, and/or training needed to care for the individual. The lack of discharge protection that this leads to is a fear of guardians of individuals with DD, especially for those with significant medical complexity. These fears are because often there is a sudden discontinuation of care increasing the risk of additional destabilization, limited alternatives for care especially in rural or underserved areas, emotional impact and stigmatization of being told you are “too complex,” lack of coordination between healthcare systems / providers creating high risk gaps in care.

Closing Virginia’s healthcare gaps for individuals with developmental disabilities (DD) requires a comprehensive, cross-sector response. This effort must include investments in workforce development to equip providers with the skills needed for person-centered care, expansion of access in underserved and rural areas, and removal of financial barriers that delay or prevent critical medical interventions. HDMC plays a vital role in bridging these gaps today. Its team of experienced healthcare professionals provide complex medical care tailored to individuals with DD, taking the time necessary to understand layered needs and develop individualized treatment plans. Critically, care is provided regardless of insurance status. HDMC also admits individuals in urgent situations, such as those involved with Adult Protective Services needing immediate safe placement, or during transitions to higher-acuity care settings. Virginia’s future depends on building systems that reflect this level of responsiveness, equity, and expertise so that no individual is left behind.

The age at which someone with a Developmental Disability (DD) might need the level of care provided by HDMC and specifically nursing facility care depends heavily on their individual health, support system, and environment, not just their diagnosis. The chart below shows the status and ages of individuals enrolled in the DD Waiver and on the DD Waiver Waitlist. As of July 9, 2025, there were 1,535 people with DD currently 65-years and older. As seen below, there were 1,261 people with DD ages 59-64 years projected to reach the identified category of an “older adult” within 6 years. (5)

of Individuals on various Enrollment Statuses or Waitlist by Age Categories as of 7/9/2025

Enrollment Status or WL	a) <=58	b) Turning 65+ on waiver in next six years 59-64 as of 7/9/2025	c) 65+ as of 7/9/2025	Total
Accepted	420	4	8	432
Active	15,982	1,150	1,431	18,563
Hold	28	3	0	31
Pending Appeal	31	0	2	33
Projected	246	7	2	255
Waitlist	13,809	97	96	14,002
Total	30,516	1,261	1,539	33,316

Serious Mental Illness

Virginia's behavioral health system faces significant gaps that directly impact individuals with SMI, but HDMC helps fill these gaps by functioning as both a stabilizing resource and a bridge back to community supports. Much like the DD community, these challenges are shaped by systemic, geographic, financial, and social factors. Virginia has a critical shortage of psychiatrists and behavioral health professionals, especially in rural and underserved areas. (1, 2) Lack of coordination between crisis care, outpatient services, and long-term support leads to gaps in treatment continuity. (1) Individuals with SMI often face social stigma, which can discourage help-seeking and affect provider attitudes. (2) High out-of-pocket costs and limited Medicaid reimbursement rates restrict access to consistent care. (3,4) Many individuals with SMI lack stable housing or reliable transportation, making it difficult to attend appointments. (5, 6) Long term care beds for individuals with SMI discharging from state DBHDS facilities to nursing facilities are at a premium, which leads to longer wait times for discharge. (7)

Within DBHDS facilities, there are 1755 individuals with an SMI related ICD10 code. There are 4 Geriatric Centers at DBHDS facilities for Behavioral Health including Piedmont Geriatric Hospital (PGH), Eastern State Hospital (ESH), Catawba Hospital (CH), and Southwestern Virginia Mental Health Institute (SWVMHI). The number of individuals in each of these centers is included in the table below.

Hospital	# of Geriatric Individuals	Grand Total
Catawba Hospital	63	63
Eastern State Hospital	32	32
Piedmont Geriatric Hospital	123	123
Southwestern Virginia Mental Health Institute	38	38
Grand Total	256	256

The Substance Abuse and Mental Health Services Administration estimates that 4.86% of individuals over age 26 in Virginia have a diagnosis of a SMI. (8)

Individuals with SMI from other DBHDS facilities access HDMC services for acute medical issues, medical declines requiring additional care after a GM stay or skilled care, may be admitted to a SNF or NF bed. On occasion, DBHDS facilities have requested that the person stay at HDMC until a discharge placement is determined due to the person's ongoing medical needs. Some individuals have been admitted to SNF or NF beds as permanent admission. This simply means that the person has been discharged from the DBHDS behavioral health facility. Discharge planning can continue. If the person or their Authorized Representative (AR) or Legal Guardian (LG) wishes for the person to discharge to a community placement, HDMC works on this discharge as well. One advantage to individuals, whether on special hospitalization or permanent status, is the fact that the person can show success in a nursing facility environment. This can be an advantage, particularly when discharging to another nursing facility.

The age at which someone with a Severe Mental Illness (SMI) might need the level of care provided by HDMC and specifically nursing facility care depends heavily on their individual health, support system, and living environment, not just their diagnosis.

The need for people with SMI's to access care in a nursing home may vary widely but they often enter nursing homes in their 50's and 60's as compared to the general population typical admission age of 75 – 85 because they often face co-occurring medical conditions, poor health management, and limited social support. It is important to note that the prevalence of SMI in nursing facilities has increased by 77% over the past decade. These patients often have a lack of family or caregiver support, histories of homelessness or incarceration and struggle with medication adherence and safety awareness. (2)

Sexually Violent Predator

Virginia's behavioral health system must address the complex medical needs and the social stigma that often surrounds individuals with forensic histories. The Virginia Center for Behavioral Rehabilitation (VCBR) serves individuals designated as sexually violent predators (SVPs), many of whom, due to aging, chronic illness, or disability, require skilled and long-term medical care that VCBR is not equipped to provide. HDMC fills this gap by offering a less restrictive, clinically appropriate environment where these individuals can receive dignified care. Whether admitted for short-term stabilization or long-term support, HDMC ensures continuity of treatment, holistic care coordination, and a path toward community reentry when safe and feasible. Importantly, some individuals return to VCBR not because of reoffense, but because community placements

fail, often due to stigma or medical declines. HDMC's ability to maintain medical oversight during these transitions allows for safer, person-centered discharge planning without interrupting critical services. With 62 individuals aged 65 and over currently residing at VCBR, and aging-related medical needs increasing, HDMC plays an indispensable role in preventing unnecessary institutionalization and ensuring that medical acuity, not history, guides treatment pathways.

Number of Virginia Center for Behavioral Rehabilitation (VCBR) Residents Who Are Currently the Median Age for Nursing Home Admissions (65 or older)

Current AGE	# of Residents
65	7
66	7
67	9
68	9
69	6
70	6
71	1
72	6
75	1
76	1
77	2
78	2
83	2
85	1
87	1
88	1
Total	62

The DBHDS Office of SVP Services estimates they are currently tracking 35 individuals with varying degrees of medical issues that could potentially lead to an admission or readmission to VCBR. Please note that not all individuals on conditional release have been to VCBR prior to being placed in the community. Per the VCBR Director of Forensic Services, within 6 years, 67 VCBR residents will become 65 years or older.

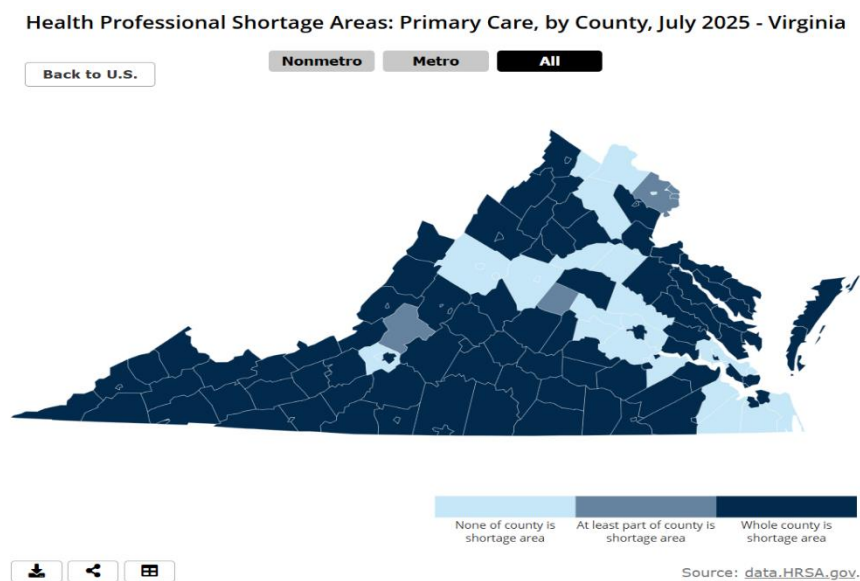
Number of Virginia Center for Behavioral Rehabilitation (VCBR) Residents Who Are Currently the Median Age for Nursing Home Admissions (65 or older)

Current Age	# of Residents
59	9
60	12
61	11
62	12
63	13
64	10
Total	67

Economic and Workforce Considerations

Virginia is facing a multifaceted healthcare workforce crisis, with several key challenges impacting care delivery across the state. There are critical shortages in key professions. There's a significant shortage of registered nurses, licensed practical nurses, and certified nursing assistants, especially in long-term care and rural areas. Over 40% of Virginians live in areas with a shortage of mental health professionals, prompting urgent action. (1)

- As of July 2025, many counties in Virginia are federally designated Health Professional Shortage Areas (HPSAs) for primary care, dental, or mental health services. These designations can apply to entire counties, parts of counties, or specific facilities within them. (2) For example, the following map shows the counties and cities in Virginia that are designated as having a shortage of Primary Care Providers (PCP). 104 out of 133 counties and cities are considered to have a significant shortage in PCPs and are designated shortage areas. (1, 2)



The dire status of the healthcare workforce in the Commonwealth is found throughout the nation. The American Network of Community Options, (ANCOR) a national nonprofit trade association representing more than 1,600 private community providers of services to people with disabilities, conducted a survey to measure the impact of the workforce crisis on both providers and the people they support. The 2024 survey obtained responses from 496 distinct providers, representing 47 states and the District of Columbia. The results of the 2024 survey are a sobering revelation of a system of care in peril. (3)

Of the community providers who responded to this year's survey (3):

- 90% experienced moderate or severe staffing challenges in the past year.
- 69% reported turning away new referrals
- 39% were discontinuing programs / services.
- 64% intended to delay the launch of new programs
- 34% were considering further cuts to programs if recruitment and retention challenges failed to subside.
- 45% were experiencing more frequent reportable incidents
- 57% of case managers struggled to connect people with services
- 57% reported delivering services in areas where few or no other options exist.

Staff at HDMC have decades of experience caring for complex patients. Closure of HDMC would risk losing that medical expertise, particularly in a climate of a statewide and nationwide crisis of healthcare providers.

Infrastructure vs. Investment

- The ideas of renovating a new HDMC, building a new HDMC, and using the campus and buildings of the previous Central Virginia Training Center (CVTC) in Lynchburg were explored. DBHDS estimates from 2018, included that a new HDMC would cost \$94 million and a new HDMC would cost approximately \$150 million. These estimates included 4 person rooms which are not compliant with the Americans with Disabilities Act (ADA) requirements and would need to be revised. During barrier discussions, the group discovered that the CVTC buildings cannot be repurposed for use as nursing facility beds due to extensive modifications to comply with the Americans with Disabilities Act (ADA). This limitation removes a potential pathway for expanding long-term care options and reinforces the urgency of identifying viable alternatives to meet growing community needs.

HDMC discussed updates regarding the current state of HDMC included that infrastructure concerns at HDMC have been proactively addressed. Legionella is fully mitigated, water is safe, and HVAC was successfully replaced by portable units during a smoke damper project. Elevators received upgrades and ongoing maintenance; electrical systems are sound with no code violations. Plumbing incidents have been rare, five in eight years, with no major relocations or leaks in 4-person rooms. Plans confirm no water or sewage lines run above those rooms. CSH's certified HVAC, electrical, and plumbing staff are onsite for rapid response. Bathrooms now include accessible modifications and updated sinks to support hygiene and safety. (2)

HDMC has updated its Emergency Operations Plan to ensure safe and efficient evacuation protocols. To reduce risk, the facility maintains a capped census of 45 residents. In case of a localized issue, internal relocations, either vertically or horizontally, can occur without full building evacuation. Should a catastrophic event require complete evacuation, the Central Virginia Healthcare Coalition will coordinate support. Bon Secours Southside Medical Center in Petersburg, VA has confirmed availability of 50–150 beds, ensuring all HDMC residents could be relocated together with full medical coverage nearby. (2)

Current Community Resources & Concerns

- While community services for individuals with DD have shown progress over the past decade, serious gaps remain, especially for individuals with SMI or those labeled SVP. These groups face limited service options, and in some cases, SVP-designated individuals have been re-institutionalized due to medical decline. HDMC continues to serve as a vital safety net for these vulnerable populations, ensuring access to care when no other alternatives exist.

Community-based services for individuals with DD have grown into a multi-layered support system. DBHDS ensures accountability through rigorous Licensing Regulations (12VAC35-105), annual inspections, and quality reviews that monitor health, safety, inclusion, and provider competency. However, despite these safeguards, when community-based supports fail to protect the health and safety of individuals with DD, HDMC is seen as the essential safety net, providing care where no other system can.

While Virginia has helped individuals with disabilities live in home- and community-based settings, it has not ensured the well being of those who remain in institutions. (2) The Virginia Board for People with Disabilities (the Board) first identified this problem in its 2021 assessment of ICF/IDDs. Under federal law (42 C.F.R. §442.109) (3), the Virginia Department of Health must inspect each ICF/IID every 15 months to ensure compliance with Medicaid requirements - including standards for health care, treatment, protections, and staffing. Yet, oversight has faltered. As of February 2025, 95% of ICF/IID certifications were overdue, according to CMS data, a sharp rise from 32% in 2019 and 40% in July 2023, following a pause in inspections during the COVID-19 pandemic. This backlog poses serious risks to the health and safety of residents. The state's failure to enforce timely inspections represents a systemic breakdown in accountability for some of its most vulnerable citizens. Since July 2023, the rate of overdue certifications has more than doubled.

Individuals with Serious Mental Illness (SMI) face alarming health disparities. Mortality rates are 2–3 times higher than the general population, with life expectancy shortened by 10 to 28.5 years.

These gaps are driven not only by underlying psychiatric conditions but by a constellation of factors, including (6, 7):

- Co-occurring physical illnesses such as hypertension, hyperlipidemia, diabetes, and cardiovascular disease (6)
- Health behaviors and social determinants: higher smoking rates, reduced physical activity, poor nutrition, and economic instability (6)
- Structural and provider-level barriers, such as:
 - Fragmented physical and mental health services
 - Delays in care-seeking and low screening rates
 - Medication side effects and poor treatment adherence
 - Discrimination and “diagnostic overshadowing” (7)

Systemic reform is needed. A 2019 national survey of Primary Care Providers revealed that nearly 71% believe physical health care for people with SMI should be a shared responsibility between PCPs and mental health specialists. Respondents identified care coordination resources, such as health educators for behavioral counseling and nursing care coordinators, as critical for bridging gaps in service delivery. (8)

Residential placement options exist for Virginians with Serious Mental Illness (SMI), but choices become severely limited when medical complexity is involved. While group homes are available, many cannot manage higher-level medical needs. Veterans may qualify for Medical Foster Care through the VA and Assisted Living facilities can offer support with activities of daily living, yet these often lack capacity for medical services unless supplemented by outside providers. For instance, Care Advantage can integrate behavioral and medical support into home-based services. (9) However, those with more intensive medical needs often require nursing facility placement where access is constrained by insurance limitations and behavioral considerations. Identifying appropriate beds remains a major barrier.

As individuals designated as SVPs in Virginia experience medical decline in community settings, access to appropriate care becomes extremely restricted. When the level of care needed surpasses what is typically available in residential options, particularly when nursing facility care is needed, these individuals often face insurmountable barriers. In multiple cases, the inability to secure suitable medical support has led to return placements at VCBR, where care was subsequently provided through HDMC. This underscores a critical systems gap in post-release medical coordination and community-based long-term care for SVPs with complex health needs.

DBHDS lacks formal partnerships for individuals designated as SVPs. Social Workers and Community Transition Specialists assess each person's needs and work to identify suitable providers. Placement becomes particularly difficult when medical needs increase, though a few providers have accepted individuals with the SVP label. Even for individuals who have the reference to "violent" removed, discrimination in the community persists and these individuals become ineligible for services at VCBR. (9)

Virginia Nursing Facilities

Virginia has nearly 300 licensed nursing homes offering about 33,000 beds. Most accept Medicare and Medicaid, although a few do not participate. (1) Funding comes from various sources, including private pay, insurance, and public programs. Even among facilities that accept Medicaid, openings may not be available when needed.

Virginia's nursing homes vary widely in quality, as measured by the CMS Five-Star Rating System, which assesses inspections, staffing, and care metrics. (2) Of 290 facilities, only 31 earned a five-star rating for overall excellence. (1) Many struggle with staffing shortages, especially among CNAs, which affects care delivery. Roughly 20% fall below expected staffing levels, disproportionately impacting low-income residents. Homes serving more Medicaid patients and residents of color tend to receive lower staffing and inspection scores, reflecting systemic disparities. (1)

The Virginia Department of Health (VDH) oversees nursing home inspections but staffing shortages and delayed investigations have strained its capacity. Facilities must be inspected every 15 months, yet by late 2024, 66% were overdue - the fourth-highest rate nationally. VDH faced a 40% vacancy rate among inspectors, driven by low pay and high turnover. Complaint investigations have lagged for months, raising safety concerns. (3, 4, 5) A JLARC report cited issues with staffing and payments, while federal funding has remained flat despite growing demand, a rise in complaints, and required investigations. (6) VDH is working to address vacancies, particularly in HR and finance, to stabilize operations. (7)

Hiram Davis Medical Center holds a 4-star overall rating, with a 5-star score for quality measures. (8) Families have voiced concern about discharges to lower-rated community nursing facilities, especially amid growing reports of inadequate care and delayed inspections by VDH.

Families and individuals often express concern about inadequate discharge protections for those with complex medical needs. Community-based providers have limited capacity to deliver higher levels of care. In VDH-licensed facilities, discharge rules under Title 32.1 of the Virginia

Administrative Code, specifically 12VAC5-371, (9) require residents to be transferred when their needs exceed the facility's scope, as documented by a physician. A written discharge plan, notification to involved parties, and appeal rights are mandated. While intended to ensure appropriate care, these regulations can result in hospital transfers and unexpected displacement, raising anxiety about safety and continuity of care.

Medicaid cuts pose a serious risk to hospital access in Virginia, particularly for individuals with DD, SMI, or SVP designations who require hospital-level care. Of Virginia's 31 rural hospitals, 7 are at immediate risk of closure and 2 more are considered at risk, potentially eliminating up to 29% of rural hospitals. (10) This vulnerability stems from the projected impact of the "Big Beautiful Bill," signed into law on July 4, 2025, which will reduce federal Medicaid funding by over \$1 trillion across a decade. (11) Virginia hospitals could lose up to \$2 billion annually in Medicaid reimbursements. With Medicaid covering as much as 28% of patients in some areas, rural hospitals face steep revenue losses. (12, 13)

Hospital closures threaten access to emergency and inpatient care for all Virginians, especially in rural areas where travel distances may exceed 100 miles. Longer ER wait times and reduced access to basic services are likely outcomes. (11) Currently, HDMC helps fill gaps where the community system falls short, due to insurance denials, stigma, provider shortages, poor quality care, and insufficient discharge protections. Meeting the complex needs of these populations in the community would require a comprehensive care continuum that is not yet in place.

HDMC Uniqueness and Difficulty Replicating

Unique Features of HDMC and Barriers to Community Replication

- **Inclusive Admissions:** Accepts individuals denied community services due to behavioral, medical, or legal complexities.
- **Comprehensive Medical Support:** Provides access to essential medical workups and evaluations not readily available in typical residential settings.
- **Integrated On-Site Services:** Offers centralized care for diverse populations, reducing fragmentation and care gaps.
- **Specialized Disability Support:** Delivers a broad spectrum of services tailored to individuals with developmental disabilities, serious mental illness, and SVP designations all under one roof.
- **Waiver Access & Transition Time:** Serves as a bridge to community living by facilitating waiver enrollment and allowing adequate time for safe, well-planned discharges.

V. Plan and Recommendation

This implementation plan reflects the efforts of the HDMC Planning Team Community Services Subcommittee. It outlines a three-phase approach to service transformation, designed to be executed either sequentially or concurrently depending on resource availability, infrastructure readiness, and priority alignment.

Successful implementation must be grounded in core principles that balance essential health and safety requirements with the preservation of individual rights. These guiding principles serve as the ethical and operational foundation for all phases of the plan:

Guiding Principles

Individual Dignity: Respecting each person’s autonomy and privacy while ensuring they are actively involved in decisions regarding their care.

Family and Caregiver Involvement: Valuing the essential role of social support networks by engaging families and caregivers throughout the care process.

Coordinated Care Delivery: Promoting integration across all service levels to ensure seamless transitions and consistent, high-quality care.

Quality of Life: Ensuring access to safe living environments, comprehensive healthcare, meaningful relationships, and activities that promote well-being, dignity, and joy.

Continuum of Care

The subcommittee reached agreement on the importance of establishing a continuum of care. For the purposes of this initiative, Continuum of Care is defined as a coordinated network of services designed to support individuals across the lifespan. This includes tiered levels of care—from community-based and specialized medical services to rehabilitation, long-term care, and palliative support.

Ensuring seamless transitions between each stage of care is essential to delivering the right services at the right time, in the most appropriate setting. This approach would promote efficiency, improve health outcomes, and strengthen the integrity of the community-based system.

Phase 1

Continue in-patient and outpatient services from a central location.

Given the extended timeframe required to develop equivalent community-based services and ongoing concerns regarding the accessibility and quality of care for individuals with complex needs, the subcommittee recommends a targeted redesign of service delivery at HDMC.

To preserve essential support, the committee proposes maintaining residential care on the grounds of the Central State Hospital campus. This would be achieved through the construction of smaller, cottage-style residences designed to accommodate up to 40-50 individuals in total. Building a new Hiram Davis would require a cost proposal be submitted for approval. To develop a cost proposal, an initial evaluation would be completed and then a full analysis would be developed. The full analysis would require a budget request.

Estimated construction costs are comparable to those incurred at the Southeastern Virginia Training Center estimated at \$23.9M for a 16-bed cottage, with a projected timeline of 12 to 18 months. These estimates would need to be adjusted based on capacity.

Cottage-Style Residence: Based on similar projects like the Southeastern Virginia Training Center, construction costs for a small-scale, LEED-certified facility are estimated at \$23.9 million. (1)

Estimated Timeline: Projects of this scale typically require 12 to 18 months for completion, depending on permitting, site preparation, and weather conditions. (2)

Operating Estimates for 16-bed Cottage

Expense Category	2014 Estimate (3)	Adjusted for 2025 (↑35.79%) (4)
Staffing & Benefits	\$2.5M–\$3.5M	\$3.39M–\$4.85M
Utilities & Maintenance	\$300K–\$500K	\$407K–\$678K
Supplies & Equipment	\$250K–\$400K	\$339K–\$543K
Insurance & Admin	\$200K–\$300K	\$272K–\$407K
Total Annual Ops	\$3.25M–\$4.7M	\$4.41M–\$6.38M

Annual Service Reimbursement Potential: With optimized billing for hospital services, skilled nursing, and ancillary care, projected annual reimbursement depends on payer mix and service volume. Cost estimates should be determined based on services approved for inclusion using resources such as:

- [38th-snf-cost-comparison-and-industry-trends-report.pdf](#)

- <https://www.aapacn.org/resources/billing-and-reimbursement/>
- <https://www.oig.hhs.gov/reports-and-publications/workplan/summary/wp-summary-0000575.asp>

Revenue Drivers:

- Skilled nursing and Long-Term Care reimbursement rates (Medicare/Medicaid)
- General Medical/Acute Care reimbursement rates
- Ancillary services (e.g., diagnostics, therapies)
- Hospital-level care billing codes

These two steps provide a protective “safety net” for individuals who require supports that are difficult to properly meet in community settings or who have been denied access to community-based services due to behavioral complexity, limited provider expertise, or forensic status.

Proposed Service Model Components

Residential Inpatient Support

One or more 16-person cottage-style buildings for individuals requiring on-site care, including current Hiram Davis Medical Center residents who meet clinical criteria.

Short-Term Diagnostic Workups

Comprehensive medical evaluations designed to identify underlying health issues and guide individualized care planning.

Post-Acute Care Services

Transitional care for individuals recently discharged from hospital settings, facilitating safe and supported reintegration into community living.

Interim Health Stabilization Stays

Temporary accommodations for individuals experiencing significant changes in health status, allowing time for community placements to be located or modified.

Complex Discharge Planning Support

Specialized interdisciplinary services focused on navigating extended and high-need transitions, including training and post-move consultation to ensure continuity.

Protective Short-Term Stays (APS Referrals)

Emergency housing for individuals removed from unsafe environments by Adult Protective Services, offered until legal and housing barriers are resolved.

Phase 2

Enhance community support.

Establish a Virginia Center for Integrated Care including interdisciplinary internships to build community capacity. This Center would include collaboration between the DBHDS Office of Integrated Health on the community side and HDMC on the facility side. Costs incurred would be dependent on the number of additional clinical staff needed for implementation and information technology support to implement telehealth, quality assurance, and reporting functions.

Benefits:

- Build **community capacity** through interdisciplinary workforce development.
- Improve **continuity of care** for individuals with complex medical and behavioral needs.
- Drive **system innovation** through integrated training, evaluation, and shared infrastructure.

As a complementary measure to the development of the Virginia Center for Integrated Care, DBHDS recommends the establishment of a dedicated billing office that serves both HDMC and the Office of Integrated Health's mobile service programs. This centralized unit would include all core components - accounts payable, receivable, and billing operations—and be designed to optimize reimbursement across a diverse range of service categories.

The billing office would support:

- Hospital-level services provided at HDMC
- Skilled nursing and residential care within the cottage-style facility
- Ancillary supports, including diagnostics, therapies, and interdisciplinary consultations
- Mobile services, such as dental care, rehabilitation engineering, telehealth-enabled wound management, and vision evaluations

Program funding can be accomplished by implementing maximum reimbursement strategies - including accurate coding, payer-specific documentation, and telehealth billing optimization. Cost estimates should be determined based on services approved for inclusion using resources such as the Centers for Medicare and Medicaid (CMS) Cost reports, the National Academy for State Health Policy, and the Agency for Healthcare Research and Quality.

This integrated billing model would enhance financial sustainability, support service expansion, and ensure that both facility-based and mobile care delivery systems are resourced to support individuals with complex medical and behavioral profiles whose needs cannot currently be met in the community system.

Provide training and consultation to community nursing facilities and providers

To improve the quality of services across community settings, the Department of Behavioral Health and Developmental Services (DBHDS) through the Virginia Center for Integrated Care would partner with the Virginia Department of Health (VDH) Office of Licensure and Certification (OLC) to launch a targeted training and consultation program for community nursing facilities and service providers.

This initiative would feature site-specific training modules tailored to the needs and challenges of individual settings. The primary focus will be on strengthening provider competencies in supporting individuals with:

- Developmental disabilities
- Serious mental illness
- Forensic profiles, including those identified as sexually violent predators (SVP)
-

By equipping community-based staff with specialized knowledge and evidence-informed practices, the program would aim to enhance care quality, promote safety, and reduce reliance on institutional services. Ongoing consultation and technical assistance will support sustainable improvement and accountability across participating facilities.

Expand mobile services through the DBHDS Office of Integrated Health

The subcommittee proposes a strategic expansion of mobile services administered through the Office of Integrated Health to address persistent gaps in community-based care. Currently, the program provides mobile dental care, rehabilitation engineering, and on-site clinical consultations - designed to meet critical needs in the absence of locally available services.

To strengthen the continuum of care and reduce reliance on inpatient facilities, the expanded model would extend services to include:

- **Vision Evaluations:** On-site visual screening and assessments for individuals lacking access to optometric care.
- **Mobile X-Ray Services:** Portable diagnostic imaging to support timely identification of physical health conditions.
- **Non-Radiologist Swallow Evaluations** Speech and language pathologists will perform bedside swallow assessments for individuals with dysphagia or feeding challenges, reducing waiting times for radiologic procedures while ensuring timely and clinically informed dietary recommendations and care coordination.

- **Telehealth-Enabled Services** The system will expand telehealth modalities for services such as:
 - Physical therapy
 - Pressure injury prevention and monitoring
 - General wound care management

Virtual options increase flexibility, improve access in rural areas, and help maintain individuals in stable community placements, thereby reducing unnecessary hospital visits.

These additional offerings would specifically target individuals with:

- **Serious Mental Illness (SMI)**
- **Developmental Disabilities**
- **Sexually Violent Predator (SVP) designation**

By delivering high-need services directly within residential and community settings, DBHDS aims to:

- Promote earlier intervention and health stabilization
- Reduce preventable hospitalizations and inpatient admissions
- Support continuity of care for individuals with complex medical and behavioral profiles
- Increase community providers' confidence and capacity to retain individuals safely

The initiative would also incorporate enhanced data tracking to monitor service utilization, health outcomes, and cost avoidance metrics - building a foundation for long-term sustainability.

Expand the role of the DBHDS Medical Director

The DBHDS Medical Director currently plays a critical role in supporting complex clinical cases across the system. To enhance continuity, quality, and coordination in community-based care, this role should be strategically expanded to serve as a clinical integrator and advisor across settings.

This expansion would directly support the emerging **Virginia Center for Integrated Care** by offering:

- **Individual and Interdisciplinary Case Consultation** Providing targeted clinical guidance to community providers, hospitals, and rehabilitation facilities to ensure person-centered care planning and appropriate medical oversight.

- **Care Transition Leadership** Serving as a clinical liaison during hospital discharges and transitions to community settings, reducing disruptions in treatment and improving recovery outcomes.
- **Disability-Informed Treatment Reviews and Second Opinions** Identifying and advising on disability-appropriate interventions to prevent complications resulting from misaligned services, outdated protocols, or fragmented care pathways.
- **Workforce Development Collaboration** Facilitating internships for all disciplines, clinical training, and mentoring within the **Virginia Center for Integrated Care** help build statewide community care capacity.
- **Clinical Quality Assurance** Reviewing sentinel events, care patterns, and emerging medical trends to inform system-level improvements and safeguard individual outcomes.

Expanding the Medical Director's role in this manner strengthens DBHDS's ability to deliver consistent, integrated, and high-quality care for individuals with complex needs - especially those receiving services in community hospitals, skilled nursing facilities, and long-term residential settings.

Phase 3

Improve community services.

To better support individuals with complex medical and behavioral needs and reduce reliance on institutional care, targeted investment and funding expansion across key service areas is essential. DBHDS recommends the following priorities to improve care quality, accessibility, and system sustainability:

Funding Access Priorities

1. **Developmental Disability (DD) Waiver Expansion** Increase waiver availability and streamline eligibility to support more individuals with developmental disabilities in community-based settings, fostering independence and reducing institutional pressure.
2. **Discharge Assistance Program (DAP)** Expand funding for transitional services that facilitate timely and successful discharges from state-operated facilities, promoting reintegration into less restrictive environments.
3. **Housing Support for Sexually Violent Predators (SVPs)** Allocate specialized housing resources for individuals identified as SVPs who meet legal criteria for community placement, ensuring safe, monitored, and clinically appropriate living arrangements.
4. **Specialized Group Homes** Invest in group homes that integrate enhanced medical support and staffing capacity to serve individuals with behavioral health (BH) conditions and SVP designation - especially those with comorbid physical health needs.

5. **Enhanced Nursing Home (NH) Reimbursement** Increase funding to nursing homes caring for individuals with high acuity needs - including advanced activities of daily living (ADLs), instrumental activities of daily living (IADLs), complex medical conditions, and behavioral health challenges.

To enhance stability, equity, and quality across Virginia's continuum of care, DBHDS recommends targeted strategies focused on workforce development, specialized case management, and transitional care funding. These recommendations respond to persistent gaps in service dependability and staffing capacity that affect individuals with complex medical and behavioral needs.

Workforce Development & Stabilization

- **Establish a Nursing Services Workgroup** Convene a multidisciplinary task force to assess regional challenges in nursing recruitment and retention and identify actionable solutions. Key priorities include improving wage competitiveness and expanding access to clinical supervision.
- **Increase Reimbursement Rates** Advocate for higher Medicaid and state-funded reimbursement rates for nursing care across inpatient and community settings to improve availability and reliability.
- **Staffing Incentives for Community Providers** Launch initiatives to attract and retain qualified professionals in community-based settings, including sign-on bonuses, loan repayment programs, and career pathway development.
- **Establish a DSP Registry** Create and maintain a statewide **Direct Support Professional (DSP) Registry** to improve transparency, oversight, and workforce planning. The registry would:
 - Document qualifications, training status, and employment history
 - Support provider agencies in recruiting and verifying qualified staff
 - Enable centralized tracking of DSP workforce trends
 - Enhance professional recognition and elevate the role of DSPs as essential members of the care teamEstablishing a DSP registry aligns with broader efforts to formalize workforce standards and build capacity across Virginia's community service system.

Specialized Medical Case Management

- **Expand Medical Case Management Capacity at CSBs** Recruit and train medical case managers with specialized experience in complex health and behavioral conditions to improve community-based service coordination and crisis response.

Transitional Flexibility & Funding

- To support a longer, interdisciplinary transition process from inpatient settings, funding opportunities for Community Services Boards (CSBs) and prospective providers can be sourced from a mix of federal, state, and academic channels. Here's a breakdown of potential avenues:

Federal Grants

- **SAMHSA** (Substance Abuse and Mental Health Services Administration): Offers grants for transitional and integrated care models, especially for individuals with serious mental illness.
- **CMS** (Centers for Medicare & Medicaid Services): May support pilot programs through Medicaid waivers or innovation models focused on care transitions and community reintegration.

State-Level Funding

- **Virginia Department of Behavioral Health and Developmental Services (DBHDS)**: Could allocate targeted funds through the Discharge Assistance Program (DAP) or earmark appropriations for transition planning enhancements.
- **Virginia Housing Development Authority (VHDA)**: May offer housing-related funding for individuals transitioning from inpatient care, especially those with forensic or behavioral health needs.

Academic & Research Grants

- The CSBS Small Grant Program supports interdisciplinary research and program development with awards ranging from \$5,000 to \$30,000. Projects must show promise for external funding and address social and behavioral health challenges.
- Foundations such as the **Robert Wood Johnson Foundation** and **Wellcome Trust** regularly fund initiatives focused on health equity, care transitions, and mental health innovation.

Medicaid Flexibility

- Seek approval for **Targeted Case Management billing** in alternate Medicaid settings to support extended transition planning and interdisciplinary coordination.

Conclusion

Virginia has made meaningful strides in integrating individuals with complex health and behavioral needs into the broader community service system. These advancements reflect a growing commitment to person-centered care, service equity, and community inclusion. However, critical gaps remain - especially for underserved and vulnerable populations served by DBHDS. These gaps often result in reliance on non-community-based settings and fragmented care delivery.

DBHDS should reaffirm its commitment to:

- Recognizing and building upon the progress made to date
- Identifying and resolving persistent system challenges
- Advancing policies and practices that support safe, inclusive, and clinically appropriate care in the least restrictive setting possible

This commitment is essential to creating a more responsive, resilient, and equitable service system - one where all individuals, regardless of complexity, have the opportunity to thrive in their communities.

V. Additional Background Information

Developmental Disability Intermediate Care Facilities (ICFs) for Individuals with Developmental Disabilities

Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs) are a specialized layer of community support. They offer residential care and active treatment programs for people with significant developmental and intellectual challenges, aiming to improve or maintain physical, mental, and social functioning. Sources: (1), (2)

Demographic						Total (unique)
Number of ICF/IID non-state operated beds for children						116
Number of ICF/IID non-state operated beds for adults						400
Demographic	Total	Region 1	Region 2	Region 3	Region 4	Region 5
Number of Individuals in Training Centers	66↓					66
Number of children residing in ICF/IIDs	103↓					
Number of adults residing in ICF/IIDs (excluding Training Center)	337↓					

LINK: [Provider-Data-Summary-Report-May-2025-final.pdf](#) (page 22) (3)

Quality of Care in ICFs

The Virginia Department of Health reported that delays were due to staffing problems. They requested funds to hire more staff and planned to change their contracting practices. Unfortunately, these staffing challenges continued. A November 2024 report by the Joint Legislative Audit and Review Commission said the agency could not inspect facilities on time because it did not have enough staff. (4)

6-year projection of Children “Aging-Out” of ICF Level of Care

Demographic Information

Facility	0-10 Years	11-17 Years	18-20 Years	21-22 Years (Aging Out)
St. Mary’s	17	33	21	8
Holiday House	2	21	3	1
Total	19	54	24	9

Approximately, 39 children are expected to be “aging out” in the next 6 years. *Source: Dr. Benita Holland, PhD Family Resource Consultant Manager*

Services for Individuals with SMI

The Virginia Department of Behavioral Health and Developmental Services (DBHDS) licenses public and private providers that deliver services to individuals with Serious Mental Illness (SMI). However, DBHDS does not currently publish a clear count of licensed providers specializing in SMI-related care. (1)

Licensed providers offer a range of services across various settings and levels of care, including:

- Outpatient Services
- Intensive In-Home Services
- Assertive Community Treatment (ACT)
- Mental Health Skill-Building Services (MHSS)
- Crisis Stabilization Services
- Psychosocial Rehabilitation
- Supervised Living Services
- Case Management Services
- Partial Hospitalization and Day Treatment

Residential services are also provided by entities such as Therapeutic Group Homes and Adult Supervised Living facilities. (1)

DBHDS is legally mandated to conduct annual unannounced inspections of all licensed facilities—public and private—that serve individuals with SMI. These inspections assess the adequacy of individual service plans in meeting identified needs, evaluate provider compliance with licensing regulations, and review implementation of corrective actions stemming from previous deficiencies. (2)

There is currently no documented pattern of inspections being systematically omitted or left incomplete for private providers. The DBHDS Office of Licensing conducts reviews using a standardized checklist and evaluates documentation either onsite or via the CONNECT portal. (2)

Partnerships between DBHDS and Community Providers

The Virginia Department of Behavioral Health and Developmental Services (DBHDS) employs Community Transition Specialists throughout the Commonwealth to facilitate appropriate discharge placements for individuals with SMI. These specialists maintain regional knowledge of available service providers and work closely with stakeholders to ensure effective transitions into community-based care. (1)

Funding for community placements is supported through multiple channels, including:

- Medicaid coverage via the individual's Managed Care Organization (MCO)
- Veterans Affairs (VA) benefits
- DBHDS-administered Discharge Assistance Program (DAP) funds
- Private payment options

DBHDS has partnerships with a wide range of community providers to support individuals with Serious Mental Illness (SMI), particularly through its Permanent Supportive Housing (PSH) program. These partnerships and services include rental subsidies that are funded by state general funds, administered by Community Services Boards (CSBs) or private entities and integrated health services. These partnerships target individuals in state psychiatric facilities eligible for discharge, residents of supervised settings who can live independently, chronically homeless or individuals at risk of homelessness and frequent users of the emergency or criminal justice system. (3, 4)

These partnerships do not target individuals with complex medical, nursing and physical rehabilitation needs that are able to be supported by HDMC. There are significant gaps in the system of community partnerships. These include but are not limited to:

- 1) a shortage of affordable, integrated housing units across Virginia which restricts the reach of PSH programs, especially in rural or high-cost areas. (5)
- 2) PSH is not consistently used as a discharge option from state psychiatric hospitals, despite its potential to reduce readmissions and improve outcomes. (6)
- 3) high vacancy rates in clinical service positions (34%) and challenges with hiring and retaining qualified staff impact service delivery. (7)
- 4) Administrative burdens and slow licensure processes further strain providers. 4) Some individuals face lapses in care during transitions, such as youth aging out of services or hospital discharges without adequate follow-up. (8)
- 5) inconsistent coordination of supports and services between housing, health care, and behavioral services. Finally, individuals with SMI struggle to navigate eligibility requirements, waitlists, or complex application and intake processes.

Services for Individuals with an SVP Designation

The Virginia Department of Behavioral Health and Developmental Services (DBHDS) administers the Sexually Violent Predator (SVP) Program, which provides evaluation, treatment, and supervision for individuals civilly committed under Virginia law. This program is a critical component of the Commonwealth's public safety and behavioral health infrastructure. (1)

While DBHDS does not publicly list the total number of licensed SVP providers, it is known to license three Mental Health Group Homes that offer residential support to individuals designated as SVPs. In addition to residential services, DBHDS licenses and regulates providers who deliver sex offender treatment services, and it contracts with a range of professionals and facilities to ensure comprehensive care for SVP clients. (2)

Licensing and Oversight Requirements

Providers serving SVPs must comply with 12VAC35-105, the *Rules and Regulations for Licensing Providers* in Virginia. These regulations are designed to uphold public safety, clinical quality, and legal compliance. Key requirements include Health, Safety, and Welfare Standards such as providers must meet minimum standards to ensure safe and effective care, clinical staff must be credentialed according to DBHDS and Department of Health Professions (DHP) guidelines and supervisors overseeing SVP services must have at least three years of relevant experience and completion of DHP-approved supervisor training. (3)

DBHDS enforces compliance through unannounced site visits and credentialing reviews. The Office of Licensing uses a standardized checklist and reviews documentation either onsite or via the CONNECT portal. (4) Required documentation includes:

- Licensure verification
- Educational credentials
- Fitness-for-duty attestations

There is no evidence of systemic gaps in DBHDS inspections of private licensed facilities. The department maintains a consistent and rigorous oversight process to ensure that SVP providers meet all regulatory obligations. (4)

Partnerships between DBHDS and community providers for individuals with sexual behaviors, who are on the sex offender registry or are determined to be an SVP

The following list includes providers who have been willing to consider and admit individuals with sexual behaviors and/or who are listed on the Virginia Sex Offender Registry. Nursing Facilities will not accept individuals with the SVP designation but some of the group homes and assisted living facilities will consider individuals with the SVP designation on a case-by-case basis. Providers in green have a contract with DBHDS. (1)

MH Group Homes DBHDS Licensure	Assisted Living Facilities DSS Licensure	Nursing Home CMS
Alpha Community Services - Eastern	Hawkins ALF - Central	Waverly Health & Rehab - Central
Omega - Southwest	Rochelle Home (Hopewell) - Central	Valley Health & Rehab - Southwest
Helton House Female- Central	RO referrals- East	WoodHaven - Central
	Acadia - Central	Heritage Hall - Southwest Clintwood Big Stone Gap BlackStone
	Avalon Homes - Northern	
	Claras Home - Central	
	Heart and Soul ALF - Eastern	
	Tidewater Cove - Eastern	

Gaps and Challenges for Individuals who have an SVP label

The Virginia Center for Behavioral Rehabilitation (VCBR), a secure treatment facility operated by DBHDS, faces significant challenges in meeting the medical needs of its residents—individuals civilly committed as Sexually Violent Predators (SVPs).

There are Medical Care Limitations such as limited onsite medical services, especially for complex or chronic conditions. Residents frequently present serious health issues. These conditions require specialized and continuous care, which is difficult to deliver within a secure, non-hospital setting. Other emergencies often result in long-term hospitalization. These events disrupt treatment continuity and pose logistical challenges for secure transport and supervision. (1)

VCBR has experienced persistent overcapacity, with census projections exceeding facility limits as early as 2018. Overcrowding places pressure on the medical staff availability, treatment space and emergency response capabilities. (2)

Expansion efforts are underway to add beds and treatment space, but medical infrastructure remains a critical gap. (3) A gap that is filled when needed by the interdisciplinary team at HDMC.

6-Year Projection for SVP

The age at which someone labeled a Sexually Violent Predator (SVP) may require nursing facility care depends on their health, support system, and living conditions - not just their legal status.

SVPs typically need care for the same reasons as adults aged 75–85, driven by health rather than legal classification. While the SVP label identifies individuals convicted of certain sexual offenses deemed likely to reoffend, it doesn't directly impact physical aging. However, long-term incarceration can lead to accelerated aging, making some SVPs to require care in their 60s or earlier, especially if they have dementia, disabilities, or a terminal illness.

Nursing homes must also consider public safety, particularly if the SVP has a history of targeting vulnerable individuals. Thus, while there's no fixed age, SVPs may need nursing care earlier than average, with placement decisions shaped by complex health, legal, and ethical factors. (1)

Topics Common to All Three Populations

Workforce Challenges in Virginia – current and projected

There are barriers to recruitment & retention of healthcare personnel such as limited training capacity: A shortage of nurse educators and clinical preceptors restricts the number of students who can enter the field. Slow credentialing and licensing processes hinder timely entry into the workforce. Urban and suburban areas attract more providers, leaving rural communities underserved. (1)

Financial & structural constraints such as low Medicaid reimbursement rates impact healthcare professional shortages. These low rates discourage providers from working in underserved areas across the Commonwealth. High education costs of tuition and training expenses deter entry into healthcare careers, especially in behavioral health. (2, 3)

The Commonwealth has launched several initiatives to address these issues. Scholarship & Loan Repayment Programs are targeted at nurses, nurse practitioners, and behavioral health professionals who commit to working in underserved areas. In earn-to-learn internships and externships, nursing students gain hands-on experience while earning wages. A Behavioral Health Loan Repayment Program is available and offers up to \$50,000 in loan forgiveness for mental health professionals. Regional partnerships between employers, educators, and government agencies are working toward building talent pipelines tailored to local needs. (4)

Nearly half of all physicians' work at a for-profit establishment, while 10% work for the federal government. Group private practices currently employ 33% of all physicians in Virginia, the most of any establishment type in the state. The inpatient (19%) and outpatient (15%) departments of hospitals are also common establishment types for Virginia's physician workforce. Over one-third of all physicians expect to retire by the age of 65 which equals 11% of the current workforce who expect to retire in the next two years and 33% in the next 10 years, while half of the current workforce is expected to retire by 2044. 19% of Virginia's physician workforce participates in the Medicare program, while 66% are nonparticipating Medicare providers, that is, they do not accept Medicare reimbursement across all services but do so on a case-by-case basis. In addition, 63% of physicians participate in Virginia's Medicaid program. 31% of all physicians work in Northern Virginia, the most of any region in the state. In addition, one quarter of all physicians work in Central Virginia. (5)

About 90% of all pharmacists work in the private sector, including 61% who work at a for-profit organization. Hospital health systems were the most common working establishment type for

Virginia's pharmacist workforce, employing 25% of all professionals. Large chain pharmacies (i.e., pharmacies with more than 11 stores) also were common employers. About 47% of pharmacists expect to retire by the age of 65 and 7% of the current workforce expect to retire in the next two years and 26% in 10 years. Half of the current workforce is expected to retire by 2049. (6)

Only 7% of dentists currently work in non-metro areas of the state. Nearly 80% of dentists worked in the Northern Virginia, Central Virginia, and Hampton Roads regions. Dentists spend about 91% of their time treating patients; on average, they treat 50-74 patients per week. Ninety-three percent of dentists work in the private sector, including 89% who work at a for-profit organization. Nearly two-thirds of dentists work at a solo dental practice, while another 22% work at a group dental practice. About 49% of dentists expect to retire by the age of 65, 8% in the next 2 years and 27% of the workforce expect to retire in the next 10 years, while half of the current workforce is expected to retire by 2044. (7)

Only 56% have one full-time position, and 53% work between 30 and 39 hours per week. 93% work in the for a for profit establishment and 2% for Federal. About 67% of dental hygienists expect to retire by the age of 65, 7% in the next 2 years and 26% of the workforce expect to retire in the next 10 years, while half of the current workforce is expected to retire by 2044. (8)

Among all RNs, 91% are currently employed in the profession, 68% hold one full-time job, and 40% work between 40 and 49 hours per week. Nearly half of all RNs are employed in the non-profit sector, while another 41% are employed in the for-profit sector. Among all RNs, 42% expect to retire by the age of 65. 7% in the next 2 years and 21% of the workforce expect to retire in the next 10 years, while half of the current workforce is expected to retire by 2049. (9)

Among all LPNs, 89% are currently employed in the profession, 69% hold one full-time job, and 53% work between 40 and 49 hours per week. Three out of every five LPNs work in the for-profit sector, while another 22% work in the nonprofit sector. Among all LPNs, 32% expect to retire by the age of 65. Among LPNs who are age 50 and over, 22% expect to retire by the age of 65. 6% in the next 2 years and 21% of the workforce expect to retire in the next 10 years, while half of the current workforce is expected to retire by 2049. (10)

Among all CNAs, 85% are currently employed in the profession, 57% hold one full-time job, and 39% work between 40 and 49 hours per week. One-third of all CNAs are employed at a nursing home as their primary work location, while another 28% are employed at either an assisted living facility or a home health care establishment. Among all CNAs, 54% are under the age of 40.

Among CNAs who are under the age of 40, 94% are female. There is no projection on when the current CNA workforce is expected to retire. (11)

No workforce data exist on provider expertise in developmental disabilities (DD) or severe mental illness (SMI) because the Virginia Department of Health Professions (DHP) only allows Psychiatry, not DD or SMI, as a specialty choice. Likewise, the Serious Violent Predator (SVP) designation is a legal classification, not a medical diagnosis, so DHP does not track SVP-specific clinical competencies.

The Virginia Health Care Association, Virginia Center for Assisted Living report titled the “Survey: Long Term Care Workforce Challenges Persist” referenced in a previous section highlighted that 93% of facilities report vacancies for Certified Nursing Assistants (CNA), and that these facilities many also struggle to find qualified RN, LPN and / or CNA applicants. The Virginia Department of Health Professions 2024 report stated that 41% of CNAs were working at a new location (less than 2 years) and that only 43% had been at their current work location for more than 2 years, suggesting a relatively high turn – over rate. (12)

Ancillary Services in Virginia

X-ray

Mobile X-ray service providers offer diagnostic imaging directly at patients’ homes, nursing facilities, or assisted living centers. They typically offer same-day or next-day response times, depending on the location and urgency of the request. Providers like Mobile Images and TridentCare prioritize urgent cases through dispatch systems and often operate 365 days a year, including after-hours support. (1)

Once the scan is completed, report turnaround times for outpatient X-rays generally fall around 3 to 5 hours, with some facilities achieving even faster results depending on staffing and technology. (2)

Mobile X-ray service providers offer diagnostic imaging directly at patients’ homes, nursing facilities, or assisted living centers. (2) There is no exact count of mobile X-ray service providers that are publicly listed in Virginia.

Pharmacy (long-term care specialty pharmacy)

Long-term care (LTC) pharmacies offer delivery services, though an exact count isn’t publicly listed. These pharmacies typically serve assisted living homes, group homes, and skilled nursing facilities, and many also support in-home care.

Definitions of skilled care across the continuum

For Nursing Home Medicaid, which covers skilled nursing care in institutional settings:

- Income limit: \$2,901/month for a single applicant
- Asset limit: \$2,000 in countable assets (e.g., bank accounts, stocks)
- Spousal protections:
 - If only one spouse applies, the non-applicant spouse may retain up to \$157,920 in assets
 - The applicant may transfer income to the spouse to avoid impoverishment. (1)

Medical/Functional Eligibility

- Applicants must require a Nursing Facility Level of Care, which typically includes:
 - Assistance with Activities of Daily Living (ADLs) like bathing, dressing, eating, and toileting
 - Ongoing medical supervision or skilled nursing interventions (e.g., wound care, IV therapy)
 - A screening assessment conducted by a designated team (e.g., local health department or hospital) to determine care needs. (2)

Home-Based Skilled Nursing (CCC Plus Waiver)

- Virginia also offers community-based skilled nursing through the CCC Plus Waiver:
 - Same financial limits as institutional care
 - Must meet hospital or nursing facility level of care
 - Services include intermittent skilled nursing, personal care, respite, and assistive technology. (3)

In Virginia, skilled care across the continuum is defined through a combination of medical necessity, functional capacity, and the setting in which services are delivered. Here's how it breaks down:

- Skilled Nursing Services (Community-Based Waivers)
Virginia's FIS and CL waivers provide skilled nursing services for individuals with serious medical conditions who have exhausted their home health benefits. These services are:
 - Intermittent, up to 21 hours per week
 - Delivered in residences or community settings
 - Ordered by a Virginia-licensed physician
 - Include activities like:
 - Administering medications
 - Monitoring medical status
 - Training caregivers
 - Delegating skilled tasks to support staff Virginia Administrative Code: Skilled Nursing Service

- **Nursing Facility Care (Institutional Setting)**

For Medicaid-funded nursing facility care, individuals must meet criteria in three areas:

- Functional capacity: Assistance needed with activities of daily living (ADLs)
- Medical/nursing needs: Ongoing care that cannot be managed outpatient
- Risk of institutionalization: Without services, the individual is at risk of nursing home placement

Examples of qualifying medical needs include:

- Respiratory therapy
- Infusion therapy
- Dialysis
- Pressure ulcer care
- Chemotherapy and more Nursing Facility Criteria for Services

- **Continuum of Care Concept**

Virginia's continuum of care spans:

- Independent living
- Assisted living
- Memory care
- Skilled nursing
- Hospice/palliative care

Transitions between these levels are designed to be seamless, ensuring individuals receive appropriate care as their needs evolve. (2)

Nursing Facility Admission

PASRR process for adults and children

Pre-Admission Screening and Resident Review (PASRR)

PASRR is a process mandated by the federal Centers for Medicare and Medicaid Services to ensure appropriate placement of individuals with Serious Mental Illness (SMI), Intellectual Disability (ID), and/or Related Condition (RC) seeking Nursing Facility Placement.

Related Conditions can include but are not limited to:

- Cerebral Palsy
- Epilepsy
- Muscular Dystrophy
- Traumatic Brain Injury
- Spina Bifida

- Anoxic Brain Injury

The PASRR Team in the DBHDS office of Transition Network Supports (TNS) reports that this can be a lengthy process spanning several weeks, and community hospitals will often strongly encourage discharge for patients with DD to other services to avoid the process.

But by the end of Fiscal Year 25 Quarter Three there were 136 Nursing Facilities (NF) in Virginia caring for individuals with DD followed through the PASRR process. They reported that there were 368 individuals with DD currently residing in one of these nursing facilities.

The following tables presents the breakdown of children residing in a nursing facility by age grouping. The table identifies 6 individuals who will be seeking adult placement in the next 1 - 3 years.

Children followed by the PASRR Team at DBHDS

Children Residing in NF followed by PASRR	
Age	Total in each range
0 to 10	16
11 to 18	24
19 and 21	6

The following table presents the breakdown of adults in 2025 who requested a pre-admission screening to access nursing facility care and those admitted to a nursing facility who are currently followed in the resident review process by age grouping. The table identifies 45 individuals who will entering traditional geriatric status at age 65 in the next 10 years.

- Adults requesting NF Admission in 2025

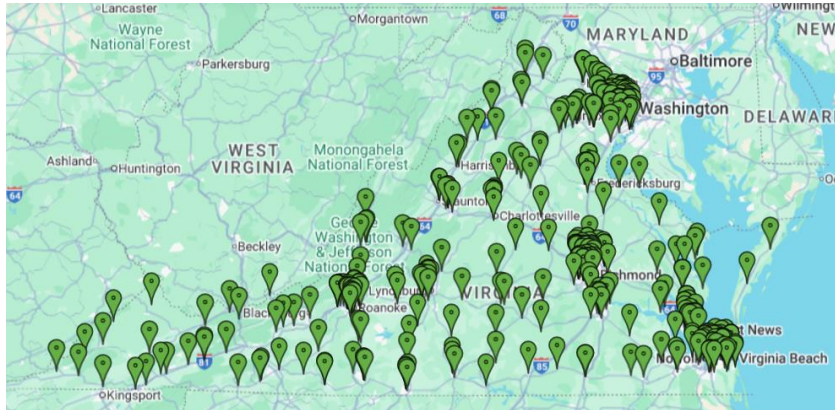
Ages	Preadmisison Screening	Resident Reviews	Total
22-34	19	0	19
35-44	5	5	10
45-54	20	23	43
55-64	62	45	107
65 and up	81	123	204

At the end of Fiscal Year 25 Quarter Three the PASRR Team reported that there were 86 Nursing Facilities (NF) in Virginia caring for individuals with Serious Mental Illness (SMI) followed through the PASRR process. There were 238 individuals with SMI currently residing in one of these facilities as reported via the PASRR. According to the PASRR Team in the office of Transition Network Supports at DBHDS there are no individuals with DD or SMI are identified

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as Sexual Violent Predators (SVP) living in community-based nursing facilities followed by PASRR.

Nursing Facilities



LINK: [Find Virginia Nursing Homes and Assisted Living Communities](#)

Based on the 202 US Census estimates for the population of 8,683,619, the current total bed count represents one bed for every 265.27 persons in Virginia. There were 27,849 residents as of January 2025, for a statewide occupancy level of 85.07 percent. Occupancy rates across Virginia hover around **85%**, meaning most of those beds are actively in use. The latest data compiled by NursingHomeDatabase.com highlights specifics regarding nursing facilities from the following 5 cities in Virginia 1) Virginia Beach, 2) Richmond, 3) Chesapeake, 4) Norfolk and 5) Arlington. (1)

- Nearly two-thirds of the nursing facilities in Virginia maintain waiting lists for new admissions. This is largely due to staffing shortages, not a lack of physical beds. In fact, 93% of facilities report vacancies for certified nursing assistants, and many struggle to find qualified applicants. (2)
- Workforce specific findings found that:
 - 93% of facilities had CNA vacancies
 - 79% have LPN vacancies
 - 72% have RN vacancies
 - 48% face shortages filling shifts.5.
- Key findings impacting access to care include:
 - Nearly two-thirds (65%) of facilities maintain a waiting list for new admissions.
 - A combined 20% of facilities had to limit admissions or considered limited admissions due to staffing shortages between July 1-September 30, 2024.5.
- Facilities are implementing strong recruitment and retention efforts, but lack of interested or qualified candidates is the primary obstacle.
 - 58% of facilities say they have no qualified applicants.
 - 24% of facilities say they have no applicants at all.5.

There are activities initiated in many facilities across the Commonwealth to mitigate the workforce challenges such as offering bonuses, increased pay and tuition assistance, compensation for participants in training programs including in – house training such as the Certified Nursing Assistant (CNA) training program that has been offered by HDMC since 2023.

There isn't a publicly available, up-to-date count of facilities that are *exclusively* private pay (i.e., do not accept Medicaid or other public funding) that this sub-committee was able to identify.

Quality of Care in Nursing Facilities

As of June 2025, 42 nursing homes in Virginia have been cited for serious deficiencies, and 244 facilities had infection-related violations. The Centers for Medicare & Medicaid Services (CMS) has imposed over \$5.5 million in penalties statewide. (1)

Henrico Health & Rehabilitation Center in Henrico County has been flagged as one of the worst in the country. The deficiency reports regarding care in this facility include:

- Long wait times for call bell responses (up to 2 hours)
- Medication errors and neglect of incontinence care
- Multiple citations for abuse and neglect, including sexual abuse by staff. (2)

Colonial Heights Rehabilitation & Nursing Center in Colonial Heights was involved in two active elder abuse prosecutions, including a case where a patient died from wounds, commonly referred to as pressure injuries, allegedly caused by inadequate care. (2)

Colonial Heights is a *for-profit* facility. It's legally registered as a Limited Liability Company (LLC) under the name *Colonial Heights Operator LLC*.^{9,10} The publicly available financial records show that despite its low ratings and staffing concerns, the facility has been highly profitable in recent years. (3)

The facility offers short-term rehab, long-term care, and specialized therapies like virtual reality and anti-gravity treadmill programs. They accept Medicare and Medicaid. Their Quality Ratings & Inspections reveal 1) Short-term rehab rating as *average*; 2) Long-term care rating: *Below average* and 3) Staffing levels as lower than state and national averages. (4)

Case: The unnamed 74-year-old woman who had cerebral palsy and diabetes, died in October 2024 from sepsis caused by severe wounds. Prosecutors alleged she was left in her own waste for days, not repositioned, and given incorrect medication. Her death led to the arrest of 18 staff members, including nurses and administrators, on charges ranging from felony abuse to falsifying records. (5, 6)

The other 42 nursing facilities in Virginia that have been identified with the most serious deficiencies have been cited for issues including but not limited to:

- Unsafe living conditions

- Poor hygiene and infection control
- Understaffing and neglect
- Examples include:

The Joint Commission on Health Care in Virginia found that one-fifth of nursing homes aren't meeting expected staffing levels, disproportionately affecting low-income residents. They also noted that the Commonwealth struggles with timely inspections and complaint investigations. (5)

Nursing Facility Oversight and Inspections

VDH

These efforts include sign-on bonuses as incentives. VDH has also been using contracted inspection teams in an effort to "catch-up" on overdue inspections. Governor Youngkin's administration has appointed a Chief Operating Officer to improve oversight and transparency. CMS has proposed shifting inspection funding to mandatory appropriations, which could guarantee more consistent support. (1)

In addition, passed Virginia House Bill 2253 (signed into law on March 19, 2025) which establishes procedures for the implementation of sanctions by the State Health Commissioner on any nursing home that is licensed pursuant to the laws regulating medical care facilities and services. The bill specifies the forms of sanctions that the Commissioner may impose, the nursing home's continued responsibility for persons under its care, the use of funds remunerated in accordance with such sanctions, the process for the imposition of such sanctions, and the Commissioner's ability to revoke such nursing home's license. The bill specifies that sanctions shall not be imposed on a nursing home that is sanctioned by the Centers for Medicare and Medicaid Services (CMS). No sanctions under this section shall be imposed for violations deemed more severe than a level 2 deficiency under the CMS deficiency severity definitions under federal law. (2)

DOJ related to ADA and Olmstead and National Nursing Home Initiative

The U.S. Department of Justice (DOJ) plays a key role in enforcing civil rights protections for people with disabilities, especially under the **Americans with Disabilities Act (ADA)** and the landmark **Olmstead v. L.C.** Supreme Court decision. Here's how these connect to the **National Nursing Home Initiative** (1):

Americans with Disabilities Act (ADA) was enacted in 1990 to prohibit discrimination against individuals with disabilities. Title II of the ADA requires public entities to provide services in the most integrated setting appropriate for individuals with disabilities. The DOJ enforces this mandate to ensure that people with disabilities are not unnecessarily institutionalized. (1)

Olmstead v. L.C. (1999) was a Supreme Court decision interpreting Title II of the ADA. They held that unjustified segregation of people with disabilities in institutions is a form of discrimination. It requires states to provide community-based services when 1) the individual prefers it, 2) it's appropriate, 3) and it can be reasonably accommodated. This decision laid the foundation for deinstitutionalization efforts and expanded access to home and community-based services (HCBS). (1)

National Nursing Home Initiative was launched by the DOJ in March 2020 to target nursing homes providing grossly substandard care. This initiative focuses on facilities that 1) fail to provide adequate staffing, 2) neglect hygiene and infection control, 3) withhold pain medication or use improper restraints, and 4) leave residents malnourished or in unsafe conditions. The initiative overall is part of the DOJ's broader Elder Justice Initiative, which aims to protect seniors from abuse, neglect, and exploitation. (1)

The ADA and Olmstead and National Nursing Home Initiative intersects in the following ways: 1) the DOJ uses the ADA and Olmstead enforcement to challenge unnecessary institutionalization in nursing homes and 2) the National Nursing Home Initiative complements these actions by holding facilities accountable for failing to meet basic care standards. Together, these efforts promote the rights of older adults and people with disabilities to live with dignity in integrated settings. (1)

These policies have a significant impact on care options and legal protections in Virginia, especially for individuals with disabilities and older adults. These policies led to the DOJ Settlement Agreement that focused on transforming the state's developmental services system. The state closed four training centers and expanded community-based services like independent housing, employment supports, and crisis services for people with Developmental Disabilities. It did not address the needs of those with Severe Mental Illness (SMI) or Sexual Violent Predator (SVP) labels. As of late 2023, Virginia was found in compliance with 89% of the DOJ's indicators, but challenges remain are being addressed under a Permanent Injunction. The National Nursing Home Initiative in Virginia reinforces oversight of long-term care providers, especially those serving Medicaid and Medicare beneficiaries. It supports efforts to ensure that nursing homes meet basic standards and that residents have access to safer, more integrated alternatives when possible. (1)

Hospitals:

Barriers to Community Based Healthcare

Virginia faces significant barriers to community healthcare access for individuals with intellectual and developmental disabilities (ID/DD), severe mental illness (SMI), and those labeled as Sexually Violent Predators (SVP). These challenges are shaped by systemic, geographic, financial, and social factors.

Individuals with ID/DD often face delays or denials in care due to behavioral complexities or stigmatizing labels, especially in emergency and end-of-life scenarios. (1) There's no universal standard for measuring hospital care quality for ID/DD populations, making it difficult to track and improve outcomes⁴. (1, 2) Hospitals often lack integrated care models, leading to poor coordination between physical and mental health services. The Veteran's Administration Health System has shown that structured care models can improve general medical outcomes for individuals with SMI. (3)

In addition to concerns around quality of care in private hospital facilities, families and individuals express fears of the lack of discharge protections especially for those with significant medical complexity. For Virginia Department of Health (VDH)-licensed hospital facilities, discharge regulations when a patient's needs exceed the facility's scope of care are primarily governed by the Virginia Administrative Code Title 32.1 and specific facility-type regulations. The specific VA Code section for Hospital Facilities (12VAC5-410-1175) (4) requires that hospital facilities discharge or transfer residents when they can no longer meet the resident's medical needs, as documented by a physician, and provide a written discharge plan. Hospitals must provide discharge planning that includes identifying a caregiver, educating them on follow-up care, and ensuring safe transition. Discharge must be coordinated with appropriate referrals and documentation. (4)

The regulation ultimately is designed to ensure individuals receive care that matches their clinical needs and protects them from being underserved. However, this can lead to individuals being sent to hospitals and discharged from their home due to a lack of skills, resources, and/or training needed to care for the individual. This possibility leads to fears and anxiety for individuals and families around the potential health and safety risks presented with a sudden discontinuation of care.

Efforts to Improve

Virginia has several state oversight & quality initiatives. DBHDS has a Mortality Review Committee that reviews deaths of individuals with ID/DD who received services from licensed providers, aiming to identify systemic improvements. (1) Regional Quality Councils include

individuals with disabilities, families, and providers who analyze data and recommend improvements across the state. (2) A Provider Capacity & Competency Workgroup focuses on training and expanding access to quality services for ID/DD populations. (3) Virginia participates in a national effort to benchmark and improve services for individuals with developmental disabilities through National Core Indicators (NCI) (4).

Managed Care Organizations

Managed Care Organization (MCO) Care Coordinators are primarily focused on ensuring their members have access to services and providers credentialed under their organization's health insurance plan details. They play a central role in supporting Medicaid members by ensuring they receive the right care at the right time. Their primary focus includes: 1) Health Screenings & Needs Assessments such as conducting health risk assessments to identify medical, behavioral, and social needs and developing individualized, person-centered care plans. 2) Care Coordination & Navigation such as helping members access medical, behavioral health, and social services, coordinating transitions between care settings (e.g., hospital to home) and facilitating communication among providers, members, and families. 3) Support for Complex Needs such as serving members with chronic conditions, disabilities, or substance use disorders and locating treatment providers, scheduling appointments, and following up on care. 4) Tracking and Monitoring such as using tools like electronic health records, claims data, and hospitalization reports to monitor member progress and updating care plans and tracking outcomes to avoid disruptions in care. 5) Addressing Social Determinants of Health such as assisting with access to food, housing, transportation, and other non-medical needs that impact health. Quality Improvement & Member Advocacy such as identifying barriers to care and advocating for member need and participating in performance improvement projects and reporting metrics to the state. (1, 2)

Research of any nationwide programs that address community services for individuals with ID/DD, SMI, and SVP

A significant number of healthcare providers report receiving none or minimal training on how to care for individuals with intellectual and developmental disabilities (IDD). For instance, a study indicated that 93.9% of medical oncology providers surveyed had received five or fewer hours of specific training related to IDD care. This lack of training contributes to barriers in healthcare access and quality for individuals with autism and IDD, leading to negative health outcomes such as lower satisfaction with care and increased emergency department utilization. The healthcare system often fails to accommodate the unique needs of individuals with IDD, resulting in communication issues and inadequate mental health support. These barriers can delay diagnosis and treatment, further exacerbating health disparities which can lead to the need for further hospitalization and / or nursing home admission. (1)

States are beginning to take meaningful steps to close the gap in health care professionals' training on developmental disabilities (DD) education, but progress is uneven and still emerging. Some are taking a multi-pronged approach to address the shortage of health care professionals trained in developmental disabilities (DD), recognizing the urgent need for inclusive, competent care. For example, states are:

Encouraging medical and public health schools to integrate DD-specific content into core training. Others are promoting continuing education. Some states offer certification programs for professionals in areas like dual diagnosis (IDD + mental illness). (2)

Requiring specialty training for staff in adult family homes, assisted living, and enhanced services facilities that serve residents with DD such as the training required in Washington State that includes core competencies in communication, behavior support, and person-centered care. In this program staff must complete this training within 120 days of hire, and it's integrated with basic long-term care worker education. (3)

Creating specialty clinics that offer training and care for people with IDD such as Kentucky's Lee Specialty Clinic. (4)

Focusing on coordination of care such as Oregon and Texas who have passed laws to improve coordination between health, education, and disability services. (4)

Incorporating DD specialty knowledge in managed care program contracts such as 1) Tennessee who requires staff in managed care programs to have I/DD-specific experience, especially medical directors and LTSS directors, 2) New York that places a strong focus on including integrating I/DD-specific quality measures in Medicare and Medicaid services for individuals with I/DD and any contracts, and 3) North Carolina requires staff have experience with I/DD populations and includes the provision in managed care contracts. (5)

The National Council on Disability and other organizations have called for 1) Mandatory disability competency education in all U.S. medical and nursing schools, 2) Designating people with disabilities as a Special Medically Underserved Population and 3) Improving data collection and requiring accessible medical equipment. (6)

Incorporating Input from Individuals with IDD: To effectively address health equity, it is crucial to include the voices and experiences of individuals with IDD in the development of public health

programs and policies. This approach ensures that the specific needs of this population are met and that healthcare professionals are better equipped to provide appropriate care.

In short, when providers lack DD-specific training, patients face real risks—poorer health outcomes, emotional distress, and systemic exclusion. But when education is inclusive and experiential, the care improves dramatically. (7)

In Virginia Va-LEND (Virginia Leadership Education in Neurodevelopmental Disabilities) that is based at VCU is an interdisciplinary program that seeks to train professionals, family members, and self-advocates to become leaders in health care and disability services. They include seminars, clinical practice, policy activities, and family mentorship which all focus on improving care for children with DD across the lifespan. (8) There is no state law or regulatory guidance from the Virginia Board of Health Professions or other oversight boards that requires health care professionals to receive specialized training regarding individuals with DD.

The Blue Ridge LEND is a collaboration between UVA, Mary Baldwin University, and regional partners, this program offers graduate-level training, technical assistance, and community engagement to improve care for individuals with autism and other DDs. Fellows receive over 300 hours of training and join a national network of professionals. (9)

Nursing facilities serve residents with a range of behavioral health needs — from mild depression, substance use, and anxiety to serious mental illness (SMI) and dementia with co-occurring psychiatric conditions. Up to 90 percent of nursing facility residents have mental health conditions, but barriers such as insufficient staff training, poor coordination with community providers, and inadequate referral systems make providing behavioral health services difficult.

States are stepping up in some creative and collaborative ways to improve care in nursing facilities for residents with serious mental illness (SMI). For example, Texas is using Money Follows the Person funds to train transition specialists and enhance staff capacity for supporting residents with SMI. They are conducting a pilot to train transition specialists who support people with serious mental illness moving out of nursing facilities. The program strengthens ties between managed care and community mental health providers and includes statewide training led by a university center, offering resources such as webinars, modules, and provider forums. Iowa is using Money Follows the Person funds to invest in training programs aimed at enhancing the quality of care and services available to individuals transitioning from institutions. New Jersey has created Olmstead Resource Teams and education coordinators to train nursing facility staff on behavioral health transitions. (10) No such program, services or training exist in the Commonwealth of Virginia.

States are implementing multisector plans for aging MPAs to coordinate and prioritize the state's goals and initiatives to address the aging population. The Oklahoma Department of Mental Health and Substance Abuse Services established an Aging Services Division to collaborate with partners on system-wide behavioral health support for older adults. The division works closely with Oklahoma Human Services, Community Living, Aging and Protective Services on the implementation of the state's Multisector Plan on Aging. (10) No such program, services or training exist in the Commonwealth of Virginia.

States such as Vermont and Colorado have incorporated behavioral health objectives into their MPA plans — bringing attention to the need for stronger collaboration among behavioral health, aging, and long-term services and support. While these objectives don't already address needs in nursing facilities they are expected to lay important groundwork for potential coordination with nursing facilities. (10) No such program, services or training exist in the Commonwealth of Virginia.

States like California, Oregon, and Vermont have leveraged Tele-behavioral health (TBH) programs like Project ECHO to connect nursing facility staff with behavioral health experts via video mentoring. No such program, services or training exist in the Commonwealth of Virginia.

Nursing facilities are encouraged to use the Center of Excellence for Behavioral Health in Nursing Facilities, which offers free training and technical assistance. The Center of Excellence for Behavioral Health in Nursing Facilities (COE-NF) is a national initiative supported by SAMHSA and CMS, and it's being promoted across many states to improve care for residents with serious mental illness (SMI), substance use disorders, and co-occurring conditions. (11, 12) For example, 1) Texas promotes COE-NF through its Medicaid managed care programs and behavioral health innovation strategies, 2) Oregon has a state-funded Center of Excellence for Behavioral Health & Aging that complements COE-NF efforts, 3) Kentucky uses Civil Monetary Penalty (CMP) funds to support dementia and behavior management training aligned with COE-NF goals, 4) New Jersey offers training through its Long-Term Care Ombudsman office and promotes COE-NF resources and 5) Delaware is piloting peer support programs in their long-term care facilities and encourages use of COE-NF for technical assistance. No such program, services or training exist in the Commonwealth of Virginia.

Mental Health First Aid for Older Adults is being encouraged as a component of staff training and continuing education programs to help caregivers recognize and respond to psychiatric symptoms across many state systems, including Virginia. (10) Whereas, this training is widely

available in the Commonwealth, there is no requirement for healthcare and service providers to obtain the certification.

The National Task Group (NTG) workshop focused on caring for adults with intellectual disabilities offers a Train-the-Trainer model, helping states including Virginia and specific facilities serving individuals with Dementia build internal capacity. (13) Virginia's DBHDS has just begun the process to make this training available in the Commonwealth for healthcare and service providers through the Office of Integrated Health.

Fears and Impact of Reduced Federal Medicaid and Medicare Funding

The "One Big Beautiful Bill Act" is shaking up the healthcare landscape, especially for nursing facilities and hospitals. Here's a breakdown of the projected impacts:

The Kaiser Family Foundation (KFF) a non-profit and non-partisan foundation that evaluates current and proposed health policy and its impact on the health of both people and the healthcare system in the United States has been evaluating the financial impact of the "One Big Beautiful Bill Act" on hospitals and hospital system. Their analysis concludes that the impact will be widespread. There will be Medicaid cuts because the bill reduces federal Medicaid spending by \$793 billion over 10 years, (1) with nearly 10% of those savings coming from limits on state-directed payments to hospitals. (2) An estimated 10.9 million more people could become uninsured, cause a spike in the uninsured and an increased uncompensated care burdens on everyone else. (3) States are expected to lose flexibility to raise Medicaid funds via provider taxes, which could also lower hospital reimbursement rates. (4) The bill could trigger \$500 billion in mandatory Medicare cuts that include a 4% reduction in hospital payments, unless, in this case Congress intervenes. (5) Finally, about 44% of rural hospitals had negative margins in 2023, and further cuts in funding, decreasing revenues, will make them especially vulnerable to closures or at a minimum service reduction. (2)

Based on KFF's analysis the financial impact of the "One Big Beautiful Bill Act" on nursing facilities (nursing homes and nursing rehab facilities) will be widespread. Future payments to nursing facilities will be capped at 100% of Medicare rates in expansion states and 110% in non-expansion states, potentially reducing funding in 29+ states. (6) The bill prohibits new provider taxes and reduces existing ones in expansion states, cutting a major source of Medicaid funding for nursing homes. (7) The bill's eligibility restrictions and work requirements could lead to millions losing coverage, affecting the 1.2 million residents in federally certified nursing facilities. (8, 9) Medicaid will cover fewer months of prior care, increasing financial strain on families and facilities. (10)

The bill does provide for a Rural Health Fund. This is a \$50 billion rural health transformation program was added to offset some losses, but KFF notes it may only cover ~37% of rural Medicaid cuts and lacks clear distribution criteria. (6)

State-operated safety net hospitals and nursing facilities are absolutely vital—especially with Medicaid cuts looming—because they serve as the backbone of care for millions of vulnerable Americans. In Virginia, HDMC serves as the backbone for individuals with DD, SMI, and SVP labels when community health and safety services fail to meet their complex needs.

HDMC offers essential services care to these underserved communities where few other options exist. There could be several significant consequences of cuts to community services. Hospitals may be forced to cut back on critical services or close departments. Thousands of jobs could be lost, further weakening the availability of healthcare providers. Entire facilities may shut down, leaving communities without access to care⁶. The need for “safety net” services HDMC provides to all three populations would significantly increase.

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