DBHDS
Virginia Department of Behavioral Health and Developmental Services

DRAFT for Public Comment

Hiram Davis Medical Center Closure Plan

Comprehensive Planning for
Safe Patient Discharges and Successful Staff Transitions

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Establishing the Planning Team Process

Background on § 37.2-316

Virginia Code § 37.2-316 was enacted in 2003 in direct response to an attempt by the department to close a state hospital without a structured public process. The General Assembly's intent was to create a clear, orderly, and transparent framework to ensure that any proposed restructuring of the state hospital system would be accompanied by a comprehensive plan and meaningful stakeholder engagement before a closure could proceed.

The statute requires the Commissioner to establish a State and Community Consensus and Planning Team when the restructuring of the system of mental health services involves an existing state hospital. The Planning Team must include a broad array of representatives: individuals receiving services, family members, advocates, state hospital employees, community services boards (CSBs), local government officials, local health and social services departments, law enforcement, area agencies on aging, private providers, and members of the General Assembly representing the service area.

The process must allow for public input, ensure that all affected stakeholders have an opportunity to be heard, and produce a plan that is reviewed by the Joint Commission on Health Care and approved by both the Governor and the General Assembly before implementation.

Commitment to Stakeholder Engagement

Consistent with § 37.2-316, DBHDS has convened the HDMC State and Community Consensus and Planning Team with broad stakeholder representation. The process is structured to:

- Maintain openness and accessibility through in-person and virtual meetings;
- Welcome and incorporate public feedback;
- Create subgroups to focus on Supporting Patients, Supporting Staff, and Ensuring Community Services; and
- Develop a comprehensive plan that emphasizes orderly, safe discharges, sustainable community capacity, and workforce stability.

DBHDS has prioritized making the planning process accessible to the public through in-person and virtual meetings, public comment opportunities, subgroup work, and ongoing communications with patients, families, staff, legislators, advocates, and providers. Stakeholders have been encouraged to share ideas, voice concerns, and propose alternatives. Every piece of input has been considered in the development of this plan, even though not all recommendations can or will be incorporated into the final version.

Balancing Stakeholder Input with Systemwide Considerations

While the closure plan reflects the recommendations from the Planning Team's subgroups, it must also account for the health of the entire service system and the Commonwealth's long-term obligations. Proposals to build a new congregate facility, for example, could raise concerns under the Americans with Disabilities Act (ADA), U.S. Supreme Court ruling in *Olmstead,* federal settlement agreements and potentially invite U.S. Department of Justice scrutiny. In contrast, the addition of 10 skilled nursing beds at SEVTC to support former training center residents is expected to be consistent with federal expectations. The closure plan, therefore, may differ from some subgroup recommendations to safeguard both individual care and the stability and sustainability of Virginia's developmental services system. However, this report includes links to all of the subgroup reports for the Governor and General Assembly's consideration.

Transition Goals and Outcomes

DBHDS's goal is to complete the closure of HDMC by December 2027, or earlier if all residents have been safely transitioned to appropriate settings. The plan emphasizes individualized, orderly discharges, continuity of essential supports, strong workforce transition strategies, and preservation of critical community services. Through this approach, DBHDS will honor the needs of current HDMC residents and staff and strengthen the Commonwealth's capacity to provide high-quality, integrated care into the future.

§ 37.2-316 Application to the HDMC Closure

While § 37.2-316 was codified over 20 years ago, the closure of HDMC marks the first time this process has been implemented. From 2012 to 2020, Virginia closed four of its five training centers, but § 37.2-316 did not apply because the training centers were not state hospitals. HDMC is not a state hospital, but it serves many populations including state hospital patients, so § 37.2-316 must apply to HDMC's closure process. As a result, DBHDS applied the § 37.2-316 process broadly, encompassing all populations served at HDMC, not solely those who came from state hospitals. This ensures that each person's needs are considered in the planning process and that every affected population benefits from the same deliberate and orderly approach envisioned by the General Assembly when the statute was created.

Commitment to an Inclusive Process

Stakeholders and Membership – The Planning Team includes representatives required by § 37.2-316 and relevant HDMC stakeholders: DBHDS staff; local officials; individuals receiving services and family members; advocates; state hospital employees; community services boards; private providers and hospitals; local health departments; social services; sheriffs; area agencies on aging; interested members of the General Assembly; and other interested persons.

HDMC Planning Team

Full Planning Team

- October 16th, 2024 at 3pm
- June 5th, 2025 at 10:30am
- September 4th, 2025 at 2:30pm

Supporting Patients Subgroup

- December 12th, 2024 at 1pm
- February 3rd, 2025 at 3pm
- March 11th, 2025 at 2pm
- April 17th, 2025 at 1pm
- May 15th, 2025 at 2:30pm
- June 17th, 2025 at 11am
- June 30th, 2025 at 3pm
- July 7th, 2025 at 11am
- July 21st, 2025 at 12pm

Supporting Staff Subgroup

- December 17th, 2024 at 9:30am
- January 29th, 2025 at 9am
- March 17th, 2025 at 3:30pm
- April 28th, 2025 at 12pm
- May 29th, 2025 at 3:30pm
- June 13th, 2025 at 12pm
- July 21st, 2025 at 3:30pm

Community Services Subgroup

- December 16th, 2024 at 10:30am
- February 6th, 2025 at 2pm
- March 25th, 2025 at 10am
- April 22nd, 2025 at 1:30pm
- May 16th, 2025 at 12pm
- June 12th, 2025 at 3pm
- June 30th, 2025 at 12pm
- July 11th, 2025 at 12pm
- July 22nd, 2025 at 2:30pm

Structure, Subgroups, and Timeline – DBHDS convened the first meeting in October 2024 following August 2024 announcement about the start of the Planning Team process. Full Planning Team meetings were held three times: once to kick off the process, an update mid-process, and a final time to review the closure plan and provide feedback. DBHDS also established three subgroups to provide expertise on specific areas and develop tailored plans: Supporting Patients, Supporting Staff, and Community Services. The subgroups were tasked with developing plans to provide to the Commissioner by August 1, 2025. The meeting schedule is found to the left.

Transparency and Public Engagement – DBHDS has emphasized open, ongoing engagement since the closure announcement, including direct outreach to families and staff, presentations to the Behavioral Health Commission and JCHC, and public meetings of the Planning Team. Full Planning Team and all subgroup meetings were open to the public, recorded, and posted on the HDMC website. Public comment was accepted at meetings and in writing via email at: hdmcplanningteam@dbhds.virginia.gov. DBHDS maintains a public webpage for all information and comment submission.

How the Subgroups Inform the Closure Plan

Supporting Patients - assesses placement options and person-centered transition planning for all HDMC populations and identifies any specialized capacity required.

Supporting Staff - develops strategies to minimize layoffs, align staff with vacancies across DBHDS (especially at Central State), and as needed, use retention incentives to ensure care continuity during ramp-down.

Community Services - identifies services that must exist in the community before closure e.g., nursing facility partnerships, behavioral supports in nursing homes, memory care, and other capabilities to meet complex medical needs, plus community education.

Importantly, while stakeholder input is critical, not all subgroup recommendations will be incorporated into the closure plan. For example, building a new congregate facility could raise concerns with the U.S. Department of Justice, while the SEVTC nursing beds are expected to meet both state and federal requirements. The closure plan balances individual needs with the long-term stability and sustainability of Virginia's developmental services system. A summary of

each subgroup's recommendations are found below and a link to each subgroup's full report is included at the bottom of this section.

Supporting Patients Subgroup Summary

The purpose of the Supporting Patients Subgroup was to identify and recommend strategies for safely and successfully transitioning all HDMC patients to appropriate, high-quality care settings in advance of the facility's planned closure by December 2027. The subgroup focused on ensuring individualized planning, preserving patient choice, and maintaining or improving quality of life during and after the transition. The subgroup included representatives from DBHDS leadership, HDMC clinical and administrative staff, community services boards (CSBs), private and public care providers, patient and family advocates, and specialists in developmental disabilities, serious mental illness, dementia, and medical care. The composition ensured expertise across the patient populations served at HDMC.

The subgroup met regularly to review detailed patient data, evaluated available placement options, and discussed service gaps. The group engaged with families, guardians, and care teams to understand patient preferences and needs. Lessons learned from previous training center closures were incorporated, and recommendations were coordinated with the Workforce and Community Services subgroups. Major subgroup recommendations included:

- **Individualized Transition Planning** – Develop a personalized transition plan for each patient, including medical, behavioral, and social support needs. Plans should be created with input from the patient, family, or guardian, and reviewed regularly until transition is complete.
- **Preserve Patient and Family Choice** – Ensure all patients and their authorized representatives are offered a range of placement options that meet their care needs, including the choice to transfer to the Southeastern Virginia Training Center (SEVTC) for those with intellectual or developmental disabilities.
- **Expand Placement Options for All Populations** – Increase availability of specialized nursing facilities, Intermediate Care Facilities, Medicaid Waiver group homes, sponsored residential settings, and mental health group homes with medical support. Ensure placements are geographically dispersed to maintain community ties.
- **Consider Rebuilding HDMC Services on a Smaller Scale** – Several family members and guardians strongly recommended that DBHDS rebuild a smaller facility in or near the current HDMC campus, maintaining the medical and rehabilitative model of care in a state-operated setting.
- **Provide Specialized Supports for Complex Medical Needs** – Develop contracts and partnerships with providers capable of supporting individuals with intensive medical needs, including tracheostomy care, ventilator support, IV therapy, and wound care.
- **Address the Needs of Non-I/DD Populations** – Secure placements for individuals with serious mental illness, dementia, or neurocognitive disorders in specialized group homes, memory care units, or nursing facilities with behavioral support services.
- **Maintain Continuity of Care During Transition** – Ensure uninterrupted access to therapies, medications, and specialized medical services during the transition period through coordination between current and receiving providers.

- **Use Trial Visits and Gradual Transitions** – When feasible, allow patients to visit prospective placements and engage in gradual transition activities to reduce anxiety and improve outcomes.
- **Monitor Post-Transition Outcomes** – Track and evaluate patient well-being, safety, and satisfaction after placement to ensure services meet the intended goals and to address any emerging concerns promptly.

Community Services Subgroup Summary

The purpose of the HDMC Planning Team Community Services subgroup was to identify and recommend the types, amounts, and locations of community services needed to support the closure of HDMC by December 2027. The subgroup's work focused on ensuring that adequate and sustainable community capacity is in place to serve current HDMC residents in alternative settings while maintaining quality of care. Membership consisted of members representing state and local government officials, community services boards (CSBs), private service providers, advocacy organizations, family members of individuals receiving services, health professionals, and representatives from relevant state facilities. Membership ensured diverse perspectives and expertise in planning for the transition of HDMC residents into community-based care.

The subgroup met regularly and included presentations from DBHDS staff, review of current HDMC patient data, examination of available and needed community services, and discussion of barriers to community placement. Public comment and stakeholder engagement were incorporated throughout the process. The subgroup coordinated closely with the Supporting Patients and Supporting Staff subgroups to align recommendations. Major workgroup recommendations included:

- **Expand Community Residential Options** – Develop and increase availability of Medicaid Waiver-funded group homes, sponsored residential homes, and private Intermediate Care Facilities (ICFs) with the ability to meet complex medical needs. Ensure geographic distribution to support placement close to individuals' home communities.
- **Enhance Specialized Medical and Behavioral Support Services** – Establish contracts and provider capacity for skilled nursing facilities, memory care units, and specialized mental health group homes that can support individuals with serious mental illness, dementia, or co-occurring disorders, including access to behavioral support services in nursing facilities.
- **Increase Capacity at Southeastern Virginia Training Center (SEVTC)** – Renovate two existing homes to provide skilled nursing-level care for individuals with intellectual and developmental disabilities (I/DD) who choose SEVTC. Expand capacity as needed to meet demand without exceeding the number of beds allowable under current legal agreements.
- **Rebuild or Develop New HDMC Services** – Some stakeholders emphasized that, alongside community service development, Virginia should invest in rebuilding HDMC on a smaller scale near the current campus, to preserve a state-operated medical center option for individuals with high medical or behavioral complexity.

- **Support Transitions with Individualized Planning** – Use DBHDS's established discharge planning process, including engagement with families and authorized representatives, to ensure all placements meet individuals' needs and preferences. Provide trial visits, transition supports, and follow-up to ensure stability after discharge.
- **Strengthen Community-Based Health Services** – Expand access to outpatient medical services, rehabilitation, therapies (physical, occupational, speech), dental care, and specialty medical care to replace services previously provided at HDMC. Consider mobile and telehealth models to improve access in rural or underserved areas.
- **Ensure Sustainable Funding** – Secure ongoing funding for the development, staffing, and operation of expanded community services, including potential use of carry-forward funds for one-time development costs and Medicaid reimbursement adjustments to sustain operations.
- **Workforce Development and Training** – Coordinate with the Supporting Staff subgroup to ensure adequate training for community providers in supporting individuals with high medical needs. This includes recruitment initiatives, retention strategies, and specialized training programs. Partner with the Virginia Department of Health to provide a "a targeted training and consultation program for community nursing facilities and service providers" given Governor Youngkin's August 11, 2025 Executive Order 52 on *Strengthening Oversight of Virginia's Nursing Homes.*
- **Monitor and Evaluate Outcomes** – Implement a structured process for monitoring placements post-transition to ensure safety, quality of care, and satisfaction. Use outcome data to make adjustments to services and supports.

Supporting Staff Subgroup Summary

The purpose of the Supporting Staff Subgroup was to develop recommendations to ensure the successful transition of HDMC employees as the facility prepares for closure by December 2027. The subgroup focused on retaining essential staff to provide quality care until the final transition, offering pathways to new employment within the DBHDS system, and minimizing layoffs. The subgroup was composed of DBHDS leadership, human resources representatives, facility administrators, representatives from Virginia Works and staff from HDMC and neighboring facilities. The membership included individuals with expertise in workforce planning, recruitment, retention, and employee benefits to ensure a broad approach to transition planning.

The subgroup met regularly to review staffing data, vacancy rates, retention needs, and lessons learned from prior state facility closures. They assessed the availability of comparable positions at other DBHDS facilities, identified skill transfer opportunities, and discussed potential incentives to retain staff during the closure process. Feedback from staff, families, and other stakeholders was incorporated. Major workgroup recommendations included:

- **Implement a Retention Bonus Program** – Establish a progressive retention bonus system to encourage key staff to remain at HDMC until their positions are no longer needed. Bonuses should be paid quarterly or in lump sums based on role and length of continued service.
- **Prioritize Placement at Central State Hospital (CSH) and Other DBHDS Facilities** – Offer affected employees comparable positions at CSH, Piedmont Geriatric Hospital,

the Virginia Center for Behavioral Rehabilitation, or other DBHDS locations within a 50-mile radius. Relocation assistance should be available for moves over 50 miles.

- **Facilitate Skill Transfers and Career Development** – Provide training and professional development to transition staff into new roles within DBHDS or in the private sector, including cross-training, certification programs, and career counseling.
- **Use Attrition to Reduce Layoffs** – Manage workforce reductions through natural attrition when possible, avoiding layoffs where comparable positions can be offered.
- **Support Retirement-Eligible Employees** – Offer counseling and information on retirement options for the 48 full-time staff members eligible for service retirement, ensuring informed decision-making.
- **Communicate Frequently and Transparently** – Maintain ongoing communication with staff through meetings, newsletters, and direct outreach to provide updates on closure timelines, job openings, and transition support resources.
- **Coordinate with Other Subgroups** – Ensure alignment with the other subgroups to synchronize patient transitions and staffing needs.

Developing the Closure Plan

As stated above, not all subgroup recommendations are included in the closure plan because the statute requires a single, executable course of action that is clinically safe, financially responsible, and achievable on a defined timeline. The subgroups were asked to surface the full range of ideas, including proposals that conflict with one another, so some were expected to be screened out against feasibility, cost, workforce, and alignment with statewide strategy. DBHDS has provided a link to all of the subgroup reports, below.

For example, the HDMC Parent Group strongly endorsed rebuilding the facility on a smaller scale in or near the current campus, and subgroup recommendations include this option, but the closure plan does not support this option. Since the current HDMC building must be closed, investment in community capacity has to be made to accommodate. As a result, rebuilding HDMC would be a double investment: funds in community capacity and then again in a new or renovated facility to serve the same populations. In addition, HDMC must be completely renovated to continue operating the facility. As described above, the aging infrastructure of HDMC will not support patient operations for much longer. All major systems are at the end of their useful life. It is unlikely the lengthy process to receive capital funding, design and plan for a new facility, and complete construction could occur before a major system failure would cause the evacuation of the building. Finally, demand across Virginia for institutional services provided by HDMC have significantly decreased over the years as described above, and it is unknown how many patients would return to a new building if one if built after a system failure causes a lengthy evacuation.

DBHDS recognizes, sincerely, that SEVTC is far from many families' homes. DBHDS is committed to choice and to working continuously with any interested family to identify willing, qualified providers closer to home and to investing in the quality, complex-care supports those providers need to say "yes." For families who do prefer SEVTC, DBHDS will maintain robust medical, behavioral, and quality oversight. For families who do not choose SEVTC for their qualifying loved one, community options and post-transition supports will be emphasized that

advance the Parent Group's goals for safety, stability, and access, without the delays, concentrated risk, and long-term costs of rebuilding a hospital on the HDMC campus.

Subgroup Report Link: DBHDS recognizes the Governor and the General Assembly may want to reference the subgroup' full reports. The subgroup reports are extremely well crafted, provide thorough details, and were critical in the development of the closure plan. The complete reports for each subgroup are posted on the HDMC Planning Team webpage at: www.dbhds.virginia.gov/facilities/hwdmc/hwdmc-planning-team.

Closure Plan for HDMC

Guiding Principles for the Closure Plan

The development of this plan has been guided by clear priorities:

- **Patient care first** – safe, individualized, high-quality care in the most appropriate setting.
- **Workforce stability** – goal of no staff layoffs, with placements in other DBHDS facilities and retention incentives.
- **Improving community services** – a focus on growing and improving safe and quality medical and long-term care services in the community for individuals with developmental disabilities and serious mental illness.
- **Stakeholder inclusion** – open, transparent process inviting a broad array of stakeholders to participate, ensuring methods to provide feedback, and making meeting details publicly available.
- **System sustainability** – responsible use of taxpayer funds, alignment with best practices, and compliance with federal expectations for integrated care.
- **Legal obligations** – full compliance with § 37.2-837(A)(3), ensuring that training center residents have the option to remain in a state training center setting and receive comparable care. For HDMC residents who qualify, this will include the opportunity to transfer to newly certified skilled nursing beds at Southeastern Virginia Training Center (SEVTC), with DBHDS providing written certification that these beds offer a quality of care comparable to that provided at HDMC in terms of medical, health, developmental, and behavioral care and safety.

As a result, the closure plan reflects the overarching goals of patient care, workforce stability, and stewardship of Virginia's behavioral health and developmental services system, and it balances stakeholder input with systemwide responsibilities. As a result, not all subgroup recommendations will be incorporated in their entirety. First and foremost, the plan prioritizes patient health, safety, and choice, with an emphasis on individualized, high-quality care in the most appropriate setting. It also pursues the goal of avoiding staff layoffs by identifying placement opportunities across DBHDS facilities. At the same time, the plan must account for the long-term sustainability of the entire system and the responsible use of taxpayer dollars.

These considerations include awareness of broader federal policy trends, such as the U.S. Department of Justice's (DOJ) increasing scrutiny of states that rely heavily on institutional

nursing facility beds, and the national push toward integrated, community-based care. While DBHDS is confident that the creation of 10 new skilled nursing beds at SEVTC for former training center residents aligns with federal requirements and will not trigger DOJ concerns, proposals to construct a new facility could raise questions about compliance with the Commonwealth's settlement obligations and the direction of system transformation. Accordingly, the closure plan will reflect a careful balance of stakeholder input, legal and policy considerations, and the long-term health of the system as a whole.

Closure Plan Details

1. Current State Snapshot

This section summarizes the current operating context to anchor transition planning. The graphic below is explained in more detail in the following text.

Facility Profile

HDMC is a state-operated medical and skilled nursing facility that has historically served individuals with complex medical needs from DBHDS facilities and the community. Major building systems are at end-of-life, and extensive repairs would require full evacuation for up to 24 months. The plan therefore proceeds to closure.

Closure Date

In August 2024, the Commissioner announced the start of the HDMC closure process and proposed the date of closure to be by December 2027. The closure plan recognizes closing HDMC would impact patients, staff, the local community, and the larger system of services and **maintains the recommendation to close HDMC by December 2027**. This date will allow the process of closing HDMC to be gradual so DBHDS can help individuals move into safe placements of their choice and ensure that their needs are appropriately met and can transition staff who would like to stay in the DBHDS system into new positions.

Patient Populations

Individuals served at HDMC include: (a) people with intellectual or developmental disabilities (ID/DD); (b) people with serious mental illness (SMI); (c) people with dementia or other neurocognitive disorders; (d) individuals admitted for short-term medical stabilization, wound care, or rehabilitation; and (e) a limited number with a

history at the Virginia Center for Behavioral Rehabilitation (VCBR). The following shows current population at HDMC and what settings individuals and authorized representatives may choose based on conversations had with authorized representatives.

Current Census	33
Current Occupancy	35%
Percent census reduction since 8/2024 closure announcement	26%
Discharges currently planned	6

Diagnosis	Anticipated Location	Count
Intellectual Disability/ Developmental Disability (ID/DD)	Waiver Group Home	8
ID/DD	Southeastern VA Training Center	5
ID/DD	Community Intermediate Care Facility	1
Mental Health/Serious Mental Illness	Community Nursing Facility	8
Dementia/ Neurocognitive	Community Nursing Facility	5
	Total	**27**

Workforce Overview

As shown below, HDMC employs a multidisciplinary workforce including nursing, direct care, pharmacy, laboratory, radiology, dental, rehabilitation therapies, and support staff. Neighboring Central State Hospital (CSH) and other DBHDS facilities have comparable roles and vacancies that can absorb HDMC staff through transfer and attrition. Several clinical departments are slated to move to CSH to preserve service continuity. Preferences of new work locations of HDMC staff are included below.

HDMC Classified Staffing (Aug 2025)	Filled
Administrative Staff	15
Clinical Staff	20
Therapy	6
Healthcare Compliance Specialists	5
Direct Service Associates	53
LPN	22
Nursing	23
Total	**144**

HDMC Departments Planned to Move to CSH	Full-time	Wage
Dental	5	
Pharmacy	14	
Laboratory	5	2
Radiology	3	
Physical Therapy	3	
Other Therapies	4	
Total	**34**	**2**

Location Preferences of HDMC Staff	# of staff	%
CSH Preferred	39	27%
CSH Transfer of Services	28	19%
Piedmont Geriatric Hospital	5	3%
Virginia Center for Rehabilitative Services	1	1%
Central Office	3	2%
Southeastern Virginia Training Center	1	1%
Eastern State Hospital	3	2%
Retiring	4	3%
Unaccounted for/Remaining	60	42%
Total	**144**	**100%**

Services Anchored at HDMC

Services delivered on the HDMC campus have included: internal medicine; pharmacy; laboratory and radiology; dental (including sedation dentistry); physical, occupational, and speech therapies; podiatry; selected surgical consults; palliative and end-of-life supports. The plan below details how these services will be maintained through CSH and community partners.

2. Operational Posture During Transition

Admissions Policy Aligned to Closure

Cease new permanent admissions. Limit temporary admissions from DBHDS facilities to time-limited, clinically necessary cases approved by a centralized review, with a preference to stabilize and discharge to community settings. Communicate policy to referring facilities, CSBs, hospitals, and families.

Life Safety and Infection Control

Maintain rigorous life-safety practices and infection control for remaining residents; continue required monitoring, mitigation, and contingency planning while census declines.

Placement Data and Progress Management

Track and report monthly: census, individual transition status, barriers, and anticipated discharge dates. Use a central dashboard to drive case conferences and unblock barriers.

Communications

Issue regular updates to families/guardians and staff; maintain a public-facing webpage with timelines, FAQs, and meeting materials; provide a single point of contact for transition questions.

Patient Transfers

Safely transitioning patients to new placements that meet their care needs and preferences

3. Patient Transition Plan (by Population)

Cross-Cutting Standards

- Individualized Transition Plan (ITP) for every person, covering medical, behavioral, social, communication, and mobility needs; developed with the individual and their authorized representative.

- Pre-move planning: records transfer, medication reconciliation, durable medical equipment (DME) and supplies, transportation, staffing handoffs, and benefits/billing readiness.
- Choice and trialing: offer a range of qualified providers and, when feasible, trial visits or virtual tours to support informed choice.
- Care continuity: align prescribers, pharmacies, therapies, and specialty clinics before moving dates; schedule post-move follow-ups.
- Post-transition monitoring: intensive check-ins at 72 hours, 14 days, 30/60/90 days, then quarterly for one year; rapid response supports to address emergent issues.
- Offer trial visits and gradual transitions whenever feasible, allowing patients to experience new settings prior to full discharge to reduce anxiety and improve outcomes.
- Ensure continuity of therapies and specialty medical services (physical, occupational, speech, dental, behavioral health) during transition, alongside medication and pharmacy continuity.
- Expand post-transition monitoring to include not only health and safety outcomes but also patient and family/guardian satisfaction and quality-of-life measures, with follow-up case conferencing if concerns arise.

As of August 29, 2025, there are 27 patients who need new residential placement

Individuals with ID/DD

Placement pathways include Medicaid Waiver Group Homes, Sponsored Residential homes, community Intermediate Care Facilities (ICF/IID), and community Nursing Facilities when medically necessary. For those who elect state facility care, Southeastern Virginia Training Center (SEVTC) will be readied to accept individuals with enhanced medical needs. Additional actions:

- Prepare SEVTC homes to meet skilled nursing/long-term care standards (environmental modifications, equipment, policies/procedures) and upskill/hire staff to required certifications.
- Execute one-time development supports for community providers (start-up, equipment, specialized training) to develop capacity for complex medical/behavioral support.
- Utilize DBHDS's established discharge process for former training center residents (choice-based, team-driven) to plan and execute moves.

Based on conversations with families, DBHDS anticipates the 14 patients with ID/DD will choose Medicaid Waiver group homes (8), SEVTC (5), or community intermediate care facilities (1). Once families choose a new location, DBHDS will work with families to identify providers and carefully plan

Individuals with SMI and Dementia/Neurocognitive Disorders

Placement pathways include specialized mental health group homes with medical supports, memory care units, and community Nursing Facilities that can support behavioral needs. Additional actions:

- Maintain/expand contracts with providers operating specialized mental health residences and memory care settings.
- Provide behavioral consultation services for individuals residing in community nursing facilities to reduce disruptions and hospitalizations.
- Establish crisis linkages (mobile crisis, step-up/step-down) for stabilization during and after transition.

DBHDS anticipates the current 13 patients with SMI and dementia/neurocognitive disorders will choose community nursing facilities. DBHDS has contracts with providers who can support HDMC patients with serious mental illness, dementia, or neurocognitive disorders

Special Hospitalization Alternatives (for other DBHDS Facilities)

Replace HDMC 'special stays' with contracted community stabilization and rehabilitation options for individuals from state hospitals, the training center, and rehabilitation center who require short-term medical care (e.g., wound care, IV therapy, tracheostomy or oxygen management). Develop referral protocols, acceptance criteria, and holding agreements with hospitals and nursing facilities to ensure timely admissions.

Individuals with VCBR Histories

For individuals with a VCBR history, identify providers with appropriate safeguards and competencies. Provide technical assistance to receiving facilities regarding risk management, care planning, and coordination with legal and public safety partners. Maintain contingency arrangements in case of denials or unexpected placement disruptions.

Post-Transition Monitoring and Quality

Implement a structured follow-up schedule and a rapid-response protocol. Monitor health outcomes, behavioral stability, incidents, emergency department usage, and family/guardian satisfaction; resolve issues promptly through case conferencing and provider technical assistance.

Community Services Build

Ensure continuity of the HDMC safety net for individuals in the community

4. Community Services Build & Continuity Plan

Replace Services Formerly Anchored at HDMC

To maintain continuity for individuals formerly relying on HDMC, the following services will be covered through CSH and community partners: pharmacy; laboratory; radiology; dental (including sedation dentistry); physical, occupational, speech, and recreational therapies; podiatry; internal medicine; general surgical consults; gynecology; and palliative/end-of-life supports.

DBHDS will retain core HDMC community services at the new Central State Hospital. The Community Services subgroup provides a plan to contract with community providers, use mobile/telehealth, and coordinate referrals to ensure community providers serve complex medical and behavioral patients who may have gone to HDMC.

Delivery Channels

- Move entire departments where appropriate to Central State Hospital (e.g., dental, laboratory, radiology, pharmacy, and therapies) to sustain access for the region.
- Contract with community providers to deliver specialty and ancillary services close to where people live.
- Use mobile and telehealth models to extend reach in rural or underserved areas and to support post-placement stability.
- Expand outpatient clinic capacity (dental, rehabilitation, specialty medical, and therapies) through community providers, supplemented by mobile and telehealth services to reach underserved areas.
- Implement a nursing facility training and consultation program in partnership with the Virginia Department of Health, consistent with Governor Youngkin's Executive Order 52 (August 2025) to strengthen oversight and quality in nursing homes.
- Incorporate long-term sustainability measures, including Medicaid rate adjustments and use of carry-forward funds where permissible, to ensure expanded community services remain viable beyond start-up grants.
- Establish a workforce development strategy for community providers, including specialized training, recruitment, and retention supports, developed in partnership with VDH and provider associations.
- Incorporate community education and technical assistance sessions for families, CSBs, and providers to ensure clarity about new service pathways and how to access supports.

Capacity Development & Funding Approach

Provide one-time development supports (start-up grants, equipment, and specialized training) to providers that commit to serving individuals with complex medical and

behavioral needs. Utilize Medicaid reimbursement mechanisms, single-case agreements where necessary, and targeted contracts to ensure operational sustainability.

Access and Coordination

- Coordinate referrals through CSBs and facility services; set clear service standards (access times, care coordination, documentation) and monitor utilization and outcomes.
- Provide transportation supports where needed.
- Implement a formal evaluation framework for community service capacity, including defined outcome measures (e.g., health/safety indicators, placement stability, family satisfaction, and provider readiness). Report results publicly on a quarterly basis.
- Require regional capacity mapping to ensure that services (group homes, ICFs, nursing facilities, outpatient clinics) are geographically distributed so individuals can transition closer to their home communities.

Staffing Plans

Retaining HDMC staff expertise in the DBHDS system and ensuring adequate coverage to meet patients' care needs as the facility downsizes

5. Workforce Transition & Retention Plan

Objectives

Preserve safe staffing for remaining residents while enabling timely placement of HDMC employees into comparable roles across DBHDS; minimize layoffs through transfers and attrition; retain critical skills within the state system.

Retention and Stability Measures

- Implement a progressive retention bonus program tied to quarters of continued service, with enhanced amounts for hard-to-fill clinical roles.
- Offer scheduling flexibility, access to training, and recognition incentives to stabilize key teams through the final transitions. Also support staff through Employee Assistance programs like counseling and work/life support as needed.
- Consider flexible hiring practices, such as "restricted positions," that allow employees to be hired for a year or another set time period but they receive the same benefits of full time employees.
- Structure the retention bonus program to allow either quarterly payments or lump-sum incentives, modeled after training center closures, with progressive increases for staff who remain through later quarters.
- Establish a standing internal staff communication channel (e.g., weekly email updates, intranet postings, town halls) to provide transparent, frequent updates on closure progress, job openings, and transition resources.

Placement Pipeline

- Provide certification and career development opportunities (e.g., dementia care, respiratory supports, wound care, behavioral supports) so staff can qualify for comparable or higher roles within DBHDS or in the private sector.
- Prioritize placement at Central State Hospital (same campus), with additional opportunities at Piedmont Geriatric Hospital, the Virginia Center for Behavioral Rehabilitation, Southeastern Virginia Training Center, and DBHDS Central Office. Provide relocation assistance for moves over 50 miles. Use a priority hiring mechanism so eligible employees receive preferential recruitment to comparable roles.

DBHDS anticipates staff attrition but will be transitioning staff as well. Of 146 FTEs, 6 departments (36 staff; 25%) will go to the new CSH, 48 are retirement-eligible, and others will receive preferential recruitment to comparable roles at other DBHDS locations

Department Moves to Central State Hospital (CSH)

Move certain whole clinical departments to CSH (dental, pharmacy, laboratory, radiology, and therapies) to maintain regional access and preserve team cohesion. Where full movement is not feasible, transition staff individually through the placement pipeline.

Training and Career Development

Provide cross-training and credentialing pathways (e.g., tracheostomy/respiratory supports, complex wound care, dementia care, and positive behavior supports). Offer career counseling, resume and interview support, and supervisor-to-supervisor handoffs to ensure successful onboarding at receiving facilities.

Retirement-Eligible Staff

Offer benefits counseling and clear timelines to retirement-eligible staff to support informed choices while maintaining adequate coverage until transition. Deliver individualized retirement counseling sessions for retirement-eligible employees to support informed decision-making and continuity of care until closure.

Minimizing Layoffs and Supporting Well-Being

Use attrition and transfers to avoid layoffs wherever possible. Provide EAP services, wellness supports, and reasonable accommodations during the transition period.

DBHDS will aim for no staff layoffs and will use retention bonuses to ensure enough staff are available to provide services to remaining residents as HDMC downsizes

6. Implementation Timeline & Milestones

The following phased timeline provides a structured path to closure by December 2027.

Phase 1

August 2024 – December 2025 – Preparation and Policy Alignment

Finalize admissions posture; establish dashboards as needed and case-conference cadence; initiate provider development and SEVTC readiness; announce retention program; begin department-level transition planning with CSH. Reduce permanent admissions to reduce risk to residents in the event HDMC is approved to close.

Phase 2

January 2025 – July 2026 – Initial Patient Transition Wave

Transition individuals with identified placements and lower transition barriers; scale post-placement monitoring; expand provider capacity where gaps are observed. SEVTC nursing beds are expected to be online in spring 2026.

Phase 3

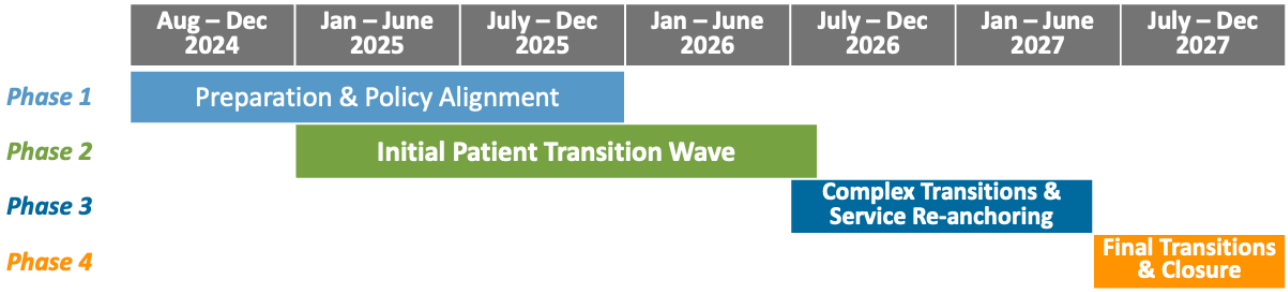
July 2026 – May 2027 Complex Transitions and Service Re-anchoring

Complete moves for individuals with high medical or behavioral complexity; move designated departments to CSH; ensure all community service contracts are active and meeting standards.

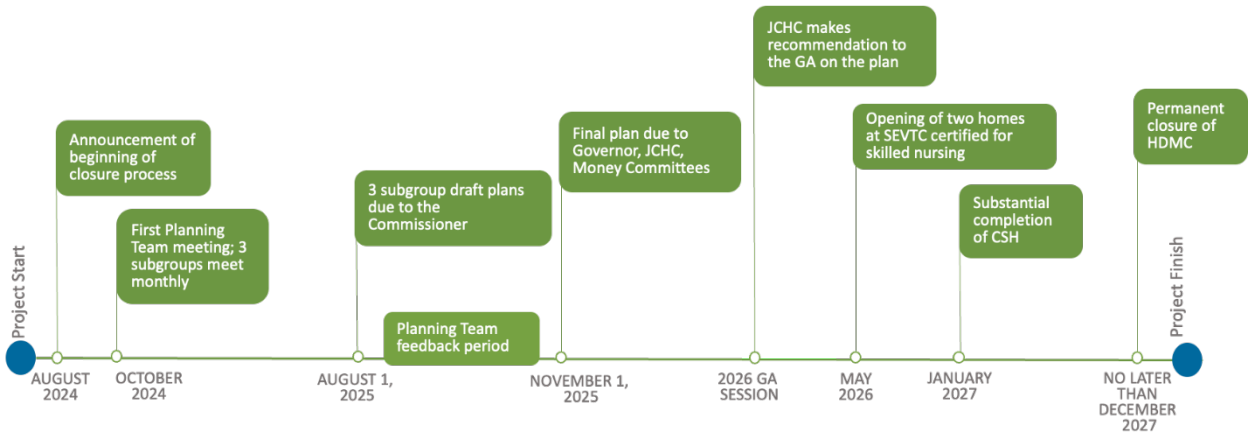
Phase 4

May 2027 – December 2027 – Final Census Draw-Down and Building Closure

Complete remaining transitions; secure records, equipment, and inventory; finalize staff placements; execute building closure procedures.



A timeline marking milestones in broad strokes from start to finish is included below:



7. Budget & Financing Overview

This plan contemplates only closure-aligned investments and operations:

- One-time costs: SEVTC home modifications and equipment; provider start-up supports; transition supports (transportation, DME set-ups); retention bonuses.
- Ongoing costs: contracted specialty services; behavioral consultation in nursing facilities; rate differentials for complex care; mobile and telehealth operations. Funding approaches will prioritize appropriate Medicaid reimbursement, targeted general fund supports, and other allowable sources to sustain services.

8. Quality, Safety, and Risk Management

Establish provider qualification standards for accepting individuals with complex needs; conduct readiness reviews; and require incident reporting, root-cause analysis, and corrective action plans when indicated. Maintain contingency placements for denials or provider disruptions. Safeguard civil and human rights, including grievance processes and independent advocacy access.

9. Governance, Reporting, and Accountability

Create a DBHDS-led project management structure with executive sponsorship and a multidisciplinary implementation team. Manage an integrated workplan spanning patient transitions, workforce, and community service build-out. Report monthly on: placements completed, time-to-placement, readmissions, critical incidents, staffing levels and placements, and service continuity metrics. Publish regular public updates.

10. Stakeholder Engagement & Communications

Engage families/guardians through recurring meetings, transition liaisons, and individualized planning sessions. Provide staff with HR clinics and a live vacancy bulletin. Convene provider readiness sessions and technical assistance. Maintain regular briefings with legislative partners and local government stakeholders.

Fiscal Analysis

§ 37.2-316 requires a six-year projection comparing the cost of the current structure and the proposed structure; in this case, that means comparing the cost of continuing to operate HDMC and the cost of closing it.

The Cost of Continued Operations

HDMC must be completely renovated to continue operating the facility. As described above, the aging infrastructure of HDMC will no longer support patient operations for much longer. All major systems are at the end of their useful life. It is unlikely the lengthy process to receive capital funding, design and plan for a new facility, and complete construction could occur before a major system failure would cause the evacuation of the building.

In addition, demand across Virginia for institutional services provided by HDMC have significantly decreased over the years as described above, and it is unknown how many patients would return to a new building if one if built after a system failure causes a lengthy evacuation.

The cost of continued operations at HDMC is shown below, allowing for the construction of a new facility.

HDMC Continual Operations							
	Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Year 6**	**6 Year Total**
HDMC Operating Costs	$18,625,415	$15,347,342	$28,654,485	$29,514,120	$30,399,543	$31,311,529	$153,852,435
Loss of Revenue	$14,400,822	$14,400,822					$28,801,644
DD Community Services General Fund	$590,000	$607,700					$1,197,700
DD Community Services Medicaid Waivers or ICF	$3,637,000	$3,746,110					$7,383,110
HDMC Capital Renovation Cost	$94,110,000						
TOTAL 6 YEAR IMPACT	**$285,344,888**						

Several assumptions were made to calculate these figures, as explained below.

HDMC Budget – The FY 2026 budget for HDMC is $28.6 million, and both scenarios are built on this assumption. This analysis does not forecast any reduction and assumes the census at HDMC remains stable.

Inflation – A three percent annual inflation increase is assumed.

Closing and Reopening of HDMC – Year 1 and Year 2 of the continual operations assume the facility is completely devoid of patients, with patients placed in community settings while renovation work is completed. A 35 percent reduction in operations is assumed, as some staff leave employment and non-personnel costs are minimized to utilities and security during the renovation. It is assumed that the remaining positions would remain in state employment; however, these employees would be temporarily reassigned to other facilities such as Central or Eastern State until HDMC is reopened. If more staff leave state employment than assumed, there will be additional hiring costs required to staff back up to allow residents to return.

HDMC Renovation Cost – The cost for renovating HDMC was provided as an overall building renovation study prepared by Virginia A&E in April 2017. This renovation cost assumes a replacement of all 94 beds at HDMC; however, HDMC is currently only at 34 percent occupancy and this number of beds is not needed. Of note, in order to get an accurate cost of a smaller number of beds, a consultant would conduct a full analysis of factors like a land survey and costs for the new footprint including patient areas, administration, and treatment areas that are not going to Central State, etc. Typically, it costs about $5,000 for an initial evaluation to get a cost proposal created because the consultant needs to get preliminary information just to understand what it will take to develop the full analysis. Depending on the cost proposal, the full analysis should be under $1 million.

The Cost of HDMC Closure

The second scenario is a six-year cost for closing HDMC and building additional community services as shown below:

HDMC Closure

	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	6 Year Total
HDMC Operating Costs	$21,926,364						
Shared Service CSH	$6,728,121	$6,929,965	$7,137,864	$7,352,000	$7,572,560	$7,799,737	$43,520,246
Medical Staff and Supplies for MH Facilities	$1,216,478	$596,478	$596,478	$596,478	$596,478	$596,478	$596,478
Retention Bonus Costs	$3,000,000						
SEVTC Operating Costs	$2,019,322	$2,079,902	$2,142,299	$2,206,568	$2,272,765	$2,340,948	$13,061,802
DD Community Services General Fund	$590,000	$607,700	$625,931	$644,709	$664,050	$683,972	$3,816,362
DD Community Services Medicaid Waivers or ICF	$3,637,000	$3,746,110	$3,858,493	$3,974,248	$4,093,476	$4,216,280	$23,525,607
WTA Costs	$2,000,000	$500,000					
Total	**$41,117,285**	**$13,960,155**	**$14,361,065**	**$14,774,002**	**$15,199,328**	**$15,637,414**	**$115,049,249**
SEVTC Capital Costs	$4,500,000						
Potential Sale of HDMC	$13,042,367	FICAS Study 2017					
TOTAL 6 YEAR IMPACT	**$119,549,249**						

Several assumptions were made to calculate these figures, as explained below.

HDMC Budget – The FY 2026 budget for HDMC is $28.6 million, and both scenarios are built on this assumption. This analysis does not forecast any reduction and assumes the census at HDMC remains stable.

Inflation – A three percent annual inflation increase is assumed.

Medical Needs – State Facilities – Many state facilities rely on HDMC for the care of medically complex patients and for training staff to manage such cases. Funding is projected to support state facilities in acquiring equipment and hiring staff to continue serving this population. This includes the ability to provide care involving PICC lines, tracheostomies, and feeding tubes.

Shared Services – Shared services include funding for Dental, Pharmacy, Lab, Radiology, and other therapies. Currently, patients at CSH receive these services through HDMC. Funding is needed to retain these staff as CSH employees. Additionally, this funding assumes partial

reductions of CSH operations that HDMC had been funding, including finance, procurement, transportation, food service, and housekeeping. The analysis assumes proportional reductions; however, some areas will not see full reductions due to the inability to split existing staff. Shared services also include funds for record retention services shared between HDMC and CSH.

Community Services – The community services estimate reflects projected costs for 28 individuals transitioning to community placements. Estimates are based on each individual's level of need and include a combination of waiver placements, ICF placements, extraordinary rates, nursing home placements, and state-funded community residential plans. This analysis assumes that five individuals that qualify for training center and nursing care will transfer to SEVTC and will not be discharged to the community. These figures can be easily adjusted should more qualifying patients decide to transfer to SEVTC.

Retention Bonus Plan – DBHDS' staffing goal in closing HDMC is to have no layoffs. However, DBHDS anticipates needing a retention bonus plan to ensure existing patients continue to receive quality care as the census decreases. The estimate provided is based on previous plans during 2012 – 2020 when DBHDS closed four of Virginia's five training centers.

Staffing with Closure – The closure scenario assumes the facility will close within one year, with all staff either transferring to other DBHDS facilities or leaving state employment. The analysis includes estimated Workforce Transition Act (WTA) costs, though final estimates will need to consider leave balances and retirement options.

Capital Costs – No additional capital costs are assumed at SEVTC over six years other than the $4.5 million already included.

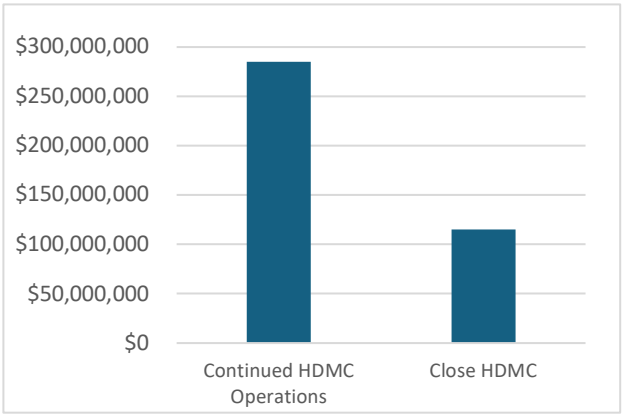
HDMC Value – The provided value of HDMC is based on a 2017 estimate, which is the most recent available from the agency. It is likely this estimate has decreased due to ongoing facility infrastructure issues.

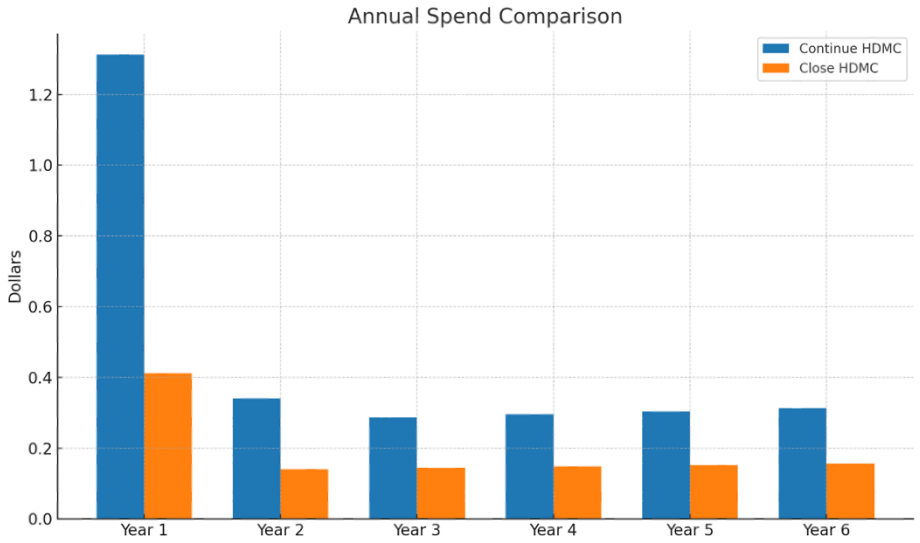
Key Findings

The six-year total to continue HDMC operation is $285,344,888, and to close HDMC and to add nursing beds at SEVTC and other community services is $115,049,249.

As a result, the six-year savings from closure (excluding any property sale) is $170,295,639. The 2017 property estimate of $13 million is realized, the savings will increase accordingly.

The image below details the annual spend comparison between these two scenarios.





The closure plan results in a $170,295,639 six-year savings, driven by avoided renovation ($94.1 million) and lower run-rate thereafter. Importantly, savings are redeployed, not removed: dollars follow the person and the service, including SEVTC readiness, community capacity, shared services at CSH, and workforce transition. The closure path reduces Year-1 cash exposure substantially and improves the structural spend by approximately $14-16 million per year thereafter.