HDMC Planning Team – Supporting Patients Subcommittee

I. Executive Summary

The HDMC Subcommittee Supporting Patients was established under Virginia Code § 37.2-316 to develop a transition plan for individuals in state hospitals. The group includes HDMC staff, DBHDS representatives, families, advocates, and providers.

HDMC distinguishes itself through its specialized services, including multiple levels of care and on-site ancillary services. No other state facility offers a comparable range or quality of services. The findings indicate that these specialized services are not easily replicated at other state facilities or within community settings.

Furthermore, a comprehensive review of the findings reveals that stakeholders widely agree that HDMC should not have been recommended for closure.

To inform potential transition options, the subcommittee conducted a comparative analysis of HDMC's on-site medical services and SEVTC's community-based model. This analysis identified significant challenges, particularly regarding placement barriers for individuals with complex medical, behavioral, or legal needs.

The planning team discussed the viability of two key outcomes. The first was a recommendation by the Family Services council to build a new smaller HDMC facility at a lesser cost in the same central location (Petersburg, VA). The new HDMC- would include a 40-50 bed facility with administrative offices/therapy spaces. The infrastructure already exits (HDMC Ancillary Services transferring to the new CSH) and an existing Shared Services Agreement between HDMC and CSH. The second outcome was in line with the commissioners original recommendation of closure. In that case the following must be addressed: expanding SEVTC levels of care, services, capacity and community partnerships. Planning prioritizes safe transitions, infrastructure improvements, and collaborative service development. The committee did request for transparency with construction of the additional skilled beds at SEVTC. They also noted a concern that the current model is not modernized.

II. Subgroup Scope and Objectives

Virginia Code § 37.2-316 requires the Commissioner establish a State and Community Consensus and Planning Team when considering the closure or conversion of any state hospital. The team must include Department staff, local officials, service recipients, families, advocates, hospital employees, community service boards, healthcare providers, aging services, law enforcement, and other stakeholders. Local General Assembly members may also participate.

The team, in collaboration with the Commissioner, must develop a comprehensive plan that:

- Projects the need for psychiatric beds and community services over six years.
- Details strategies to expand community mental health services and infrastructure.
- Ensures new community services are in place before hospital closure or conversion.
- Provides for safe, individualized transitions to community settings.
- Addresses employment transition and benefits for affected hospital staff.
- Compares the cost of current operations to the proposed changes.
- Each plan must include community education, evidence-based service models tailored to local needs, staffing strategies, individualized discharge planning, and a safeguard to suspend implementation if state funding drops by more than 10%.

  The plan must be submitted for review to the Joint Commission on Health Care and the Governor at least nine months prior to closure or conversion. Final approval rests with the General Assembly and the Governor. Any savings not allocated to individualized services must be invested in the Behavioral Health and Developmental Services Trust Fund. The Commissioner may also lease vacant state hospital space for public or private use.

III. Methodology

The subcommittee's approach to consensus-building and planning follows a structured, inclusive methodology:

- Monthly meetings were held with a broad group of stakeholders to review updates, gather feedback, and develop recommendations.
- Ad hoc meetings occurred with subcommittees, including Supporting Services and Supporting Staff, to coordinate efforts, avoid duplication, and address specific operational issues.
- The group utilized formal presentations to deliver data, budgetary information, infrastructure plans, and service overviews.
- Stakeholder input, including HDMC resident survey comments, concerns from advocates, families, and service providers, was integrated into planning discussions.
- The methodology emphasized transparent information sharing, collaboration across agencies, and identification of service gaps.
- All processes align with statutory requirements under § 37.2-316, ensuring that planning addresses clinical, operational, financial, and community-based considerations.

Through these engagements, participants have received presentations on budget updates, General Assembly initiatives, community partnerships, pilot programs, HDMC's care levels and populations served, HDMC’s on-site services, renovation costs, and discharge processes for individuals with intellectual and developmental disabilities (ID/DD

Subcommittee Participants: - Hiram W. Davis Medical Center (HDMC) Staff- HDMC Residents/Individuals Receiving Services- Department of Behavioral Health and Developmental Services (DBHDS) Staff /Office of Patient Clinical Services/Office of Integrated Health (OIH)/Office of Environment of Care- Southeastern Virginia Training Center (SEVTC)

Representatives - Family Members and Legal Guardians of Individuals Receiving Services - Disability Law Center of Virginia Advocates – Office of Human Rights Advocates- Community Service Boards (CSBs) - Community Group Home Providers - Crater District Area Agency on Aging Representatives - Local Government Officials - Members of the General Assembly Representing Affected Localities - Public and Private Service Providers - Licensed Hospitals - Local Health Department Staff - Local Social Services Department Staff - Sheriff's Office Staff - Area Agencies on Aging.

IV. Patient Population Overview and Needs Assessment

HDMC provides several levels of care to meet the diverse needs of its patient population. The facility offers General Medical/Acute Care, comparable to care in general medical hospital units, with diagnostic services (radiologic and laboratory testing), treatments that require the care of a nurse, and closer nursing oversight. To reduce hospitalization costs for the state, HDMC accepts hospital-to-hospital transfers for eligible patients.

For individuals needing more intensive oversight, HDMC provides Skilled Nursing Care in two forms. Short-term skilled care is offered to those recovering from qualifying hospital stays and is typically covered by Medicare. These services require the skills of a nurse or therapist. Long-term skilled care is available for residents with complex, ongoing medical needs, supported by Medicaid funding. These services include the need for increased direct care services, such as long-term feeding tubes and tracheostomies. These residents have more fragile medical issues and need close monitoring for safety and health.

Additionally, HDMC offers Nursing Facility or Long-Term Care for individuals with stable medical conditions and are unable to care for themselves or who require assistance with daily living. HDMC use the Minimum Data Set (commonly known as MDS) to determine the eligibility for the level of care an individual qualifies for in a nursing facility. The MDS is managed, completed, and submitted by on-site MDS Coordinators (Registered Nurses). The Minimum Data Set (MDS) is part of the federally mandated process for clinical assessments of all residents in Medicare and Medicaid certified nursing homes. This process provides a comprehensive assessment of each resident's functional capabilities and assists nursing home staff identify health problems.

The populations served at HDMC are diverse and include individuals with intellectual and developmental disabilities, those with dementia or neurological disorders, individuals with mental health or psychological disorders, persons with autism spectrum disorders, and sexually violent predators (SVPs) under state supervision. It is important to note that some populations face placement limitations due to financial, medical, psychological, or legal challenges. In some instances, individuals that reside in the community may face unexpected discharges/evictions when the community provider is unable to provide for their medical or behavioral needs. HDMC serves as a safety net for these populations.

Recent subcommittee discussions emphasized significant placement challenges for individuals with dementia, mental health conditions, or SVP backgrounds, particularly as they age and their medical needs increase. Concerns have been raised about the lack of appropriate placement options for these groups, with private sector providers often unwilling

to accept individuals with complex behavioral support needs or those requiring costly medical equipment. Enhanced behavioral supports and financial mechanisms, such as Discharge Assistance Program (DAP) funding, were proposed to improve access to community settings.

HDMC provides an extensive array of on-site services to support its residents. These include 24/7 Physician Services (Medical Doctors and Nurse Practitioners) and Nursing care Registered Nurses (RNs)/Licensed Practical Nurses (LPNs)/Certified Nursing Assistants (CNAs), Dental Services (Dentist/Dental Assistants)-Sedation and Recovery, Dietitian, Infection Control (Infection Preventionist-RN), Laboratory Services (bloodwork, cultures, microbiology, urinalysis, etc.), Oxygen Therapy/Suctioning (Respiratory Therapist), Pharmacy, Psychology Services (Part-time Psychologist/Full time Behavioral Health Training and Support Staff), Psychiatric Services (Part-time Psychiatrist), Radiology (x-ray, EKG, and ultrasound), Rehabilitation (Occupational Therapy, Physical Therapy, Speech Language Pathology, and Recreation Therapy), Social Work, Wheelchair Services (Evaluation/Customization, Maintenance and Repairs), Wound Care Nurse, Chaplain Services, Cosmetology, Telehealth Visit Coordination, and Vaccination Clinics. HDMC has a Central Medical and Equipment Services (CMES) Department to procure and maintain all medically necessary supplies and standby generator for uninterrupted medical services.

A side-by-side comparison of services provided by Hiram W. Davis Medical Center (HDMC) and Southeastern Virginia Training Center (SEVTC) further informs planning and transition strategies:

Current 1.28.25				
Services and Supports		**HDMC**		**SEVTC**
G-Tube		✓		✓
Activity Therapy		✓		✓
Catheter		✓		✓
Occupational Therapy		✓		✓
24 hour nursing		✓		✓
Speech Therapy		✓		✓
Physical Therapy		✓		X & Contract
Podiatry		Contract		Contract
Psychiatry		Contract		Contract
Wound Care		✓		Contract
Laboratory		✓		Contract
Pharmacy		✓		Contract
Dental Services		✓		Contract
Radiology, EKG		✓		Contract
Oxygen		✓		Community
Respiratory Therapy		✓		Community
Peg -Tube		✓		Community
Tracheostomy		✓		Upskill
Gastroenterology		Contract		Community
Optometry		Contract		Community
OB/GYN		Contract		Community
Pyschology		Contract		Community
Anesthesiology		Contract		Community

- **Core Medical and Therapy Services:**
  Both facilities provide G-Tube care, Activity Therapy, Catheter support, Occupational Therapy, Speech Therapy, and 24-hour Nursing. Physical Therapy is available at both locations; however, SEVTC uses both in-house and contracted services.
- **Contracted and Community-Based Services:**
  SEVTC relies heavily on contracted providers for Laboratory, Pharmacy, Dental, Radiology, Wound Care, and Psychiatric services, whereas HDMC provides many of these services onsite. SEVTC utilizes community providers for Oxygen, Respiratory Therapy, Gastroenterology, Optometry, OB/GYN, Psychology, and Anesthesiology. HDMC delivers several of these services onsite but contracts out specialized care such as Gastroenterology, OB/GYN, and Anesthesiology.
- **Specialized Supports:**
  SEVTC has introduced “Upskill” capabilities for Tracheostomy care, whereas HDMC provides this service directly. PEG-tube support is offered by both facilities, though SEVTC depends on contracted services.

This comparison underscores HDMC's comprehensive onsite medical infrastructure, while SEVTC incorporates a hybrid model leveraging contracted and community-based services. The differences in service delivery models inform discussions regarding facility upgrades, transition planning, and placement decisions for individuals requiring intensive or specialized care.

Stakeholders expressed concern regarding HDMC's Skilled on-site model vs. SEVTC's Cottage Model. Stakeholders prefer the medical, nursing, and ancillary services staff existing within the same building to allow for immediate care service delivery. At SEVTC, the medical and ancillary services are in another building, not in close proximity to the residents, requiring increased time for medical/nursing staff to address emergency situations. HDMC has dedicated staff with experience working with skilled patients/residents. Bonds have been developed between HDMC residents and the HDMC caregivers. The healthcare community/ecosystem is already established. Transitioning SEVTC (Training Center) into to a skilled model will be a gradual process. Staff will have to be hired and trained on skilled services. Stakeholders have consistently stressed their desire to not have their loved ones, who are medically fragile, be used as test patients for a newly established skilled model at SEVTC, which could pose potential risks for an already fragile population.

HDMC residents were able to share their comments through an anonymous survey on the potential closing of HDMC conducted by the Social Work Department on 7/17/25. Twelve residents participated; however, only eight residents completed the survey. Results of the survey:

Five residents out of eight prefer that HDMC remain open.
Six out of the eight enjoy living at HDMC.

The residents stated they liked the following things about living at HDMC:

- I like the doctors and nurses.
- They always answer my call light.
- HDMC is making progress as an institution.
- Staff and meals are terrific.
- I love the environment and comfort.

Seven out of eight like the convenience of having on-site services, instead of being transported to the community to have services provided.
The eight residents expressed that they are not worried about discharging to the community.

For further details, please see Attachment A (HWDMC Residents'/Patients' Potential Closing Survey and Results)

- HDMC is committed to providing a safe living environment for the residents/patients. During meetings, the following updates on improvements to the building were provided:

  Water Update- Legionella is fully mitigated. Various systems in place: Temperature regulation, Water filtration system, Ultraviolet lights, Repeated testing. Water is safe.

HVAC system- Major project-Successfully taking the whole system down on purpose and using portable heating and cooling units to successfully control the temperature in the building.

Elevators have been inspected. Upgraded with electrical and mechanical components. Routine maintenance continues.

Electrical system has been working well. There have been no code violations.

Bathroom Updates- Hair washing stations added. Some bathrooms have been modified to allow for safe and accessible access for all residents/patients.

Plumbing Updates- In the last eight years, HDMC has had 5 pipes burst, three were on a resident floor. None led to major resident moves. None in the four person rooms. Only one had sewage, which was not in a resident area. Certified plumbers at CSH are available to make any needed repairs at HDMC.

The following adjustments have been made to the HDMC Emergency Operations Plan**:**

- Keep the census to no more than 45 residents and patients
- Move residents vertically or horizontally - if there is a need to evacuate a particular area, there will be enough space to move residents to another floor or wing without evacuating the building
- Bon Secours Southside Medical Center - has informed HDMC that there are 50-150 empty beds at any one time in the hospital. HDMC could safely evacuate all residents and patients to one center that could accommodate all medical needs if total evacuation is needed

V. Plan and Recommendation

On May 30, 2025, the HDMC Family Council voted unanimously to support the following:

The Family Council at Hiram Davis Medical Center voted unanimously to support beds on the Petersburg campus for the same levels of licensed care including inpatient hospital (Medical/Surgical), outpatient hospital, skilled nursing facility, and nursing facility/ICF since Petersburg is a centralized location within the state, is DBHDS operated, and the infrastructure for all levels of care and ancillary services such as onsite pharmacy, laboratory, radiology, dental, respiratory therapy, and specialty clinics already exists.

Outpatient Services possibilities:
HDMC Hospital Services:

- Laboratory
- Radiology
- Dental
- Pharmacy
- Clinics – OB/GYN, Podiatry, GI
- Reimbursable under HDMC's Hospital Certification

- Center for Excellence (Clinical)

New CSH:

- All of the HDMC outpatient services will become part of CSH
- CSH would need to become certified to bill for services

(Community Services Subcommittee- 6/12/25 presentation)

As previously stated, the two primary outcomes were discussed

1. **Construction of a New HDMC Facility:**
    - Build a new smaller HDMC facility (40-50 bed) on the existing campus.
    - Leverage current infrastructure and ancillary services.
    - Expand the shared services agreement with Central State Hospital (CSH).
2. **Closure of HDMC with Expanded Community Capacity:**
    - Close HDMC and expand skilled nursing beds at SEVTC.
    - Implement discharge protocols for all affected residents.
    - Develop community partnerships to support SVP populations.
    - Recognize placement limitations for individuals with high medical or behavioral needs.

These outcomes were discussed with the following tenants: enhance the safety, quality, and availability of care
while addressing the ongoing infrastructure and service delivery challenges faced by the current system. Furthermore, the subcommittee emphasized the importance of addressing transfer trauma for residents, families, and legal guardians. Proposed mitigation strategies include extended trial visits, lodging assistance for families, and additional supports to ease transitions.

Another area of concern is for religious accommodation:

A Settlement Agreement dated November 11, 2021, between a current HDMC resident and DBHDS was filed in the United States District Court for the Western District of Virginia regarding religious accommodations. This agreement stipulates that the resident may not be discharged from or transferred out of DBHDS care without family consent. It also requires DBHDS to provide religious accommodations as detailed in the Third Amended Complaint, including respect for Jain Hindu religious standards and traditions. The family has expressed a preference for community access to the Jain Hindu Temple in Richmond, Virginia. Traveling from Chesapeake, Virginia would create a hardship since there is no Jain Hindu Temple in that area.

Throughout this process, the subcommittee remained committed to addressing systemic barriers to placement, ensuring continuous care for individuals unable to return to group homes, and maintaining active stakeholder engagement to resolve emerging concerns. The group has also recommended exploring the establishment of regional support centers, modeled after the DBHDS Office of Integrated Health (OIH) framework, to ensure comprehensive, statewide service availability for all individuals transitioning from HDMC. Currently, the OIH serves the ID/DD population. Any additions to the population served will require the expansion of OIH .

Infrastructure and financial considerations remain at the forefront of planning. Renovation of HDMC's current facility is estimated at $94 million, requiring a two-year

evacuation period. Full facility replacement is projected at $145 million. However, a new smaller HDMC could be built at a lower cost. Upgrading SEVTC homes to skilled nursing standards has been partially implemented, with two homes converted at $1.5 million each, not including staff upgrades and certifications.

Several unresolved challenges have been consistently highlighted in subcommittee meetings by advocates, stakeholders, and community partners. One of the most pressing issues remains the difficulty in securing appropriate placement options for individuals with dementia, mental health disorders, and those labeled as sexually violent predators (SVPs), especially as they experience medical decline. These individuals often face rejection from community providers due to the complexity of their needs, use of protective devices, or the significant cost of equipment and care.

Since the announcement of a recommendation for closure the team at HDMC and DBHDS have worked with the current patient population on preferences and needs should the facility close. As of writing this report there are 32 patients who will require alternative placement. Of those 6 have dementia; 8 have a mental health diagnosis and the remaining 18 are ID/DD. Of the patients currently admitted they 5 are likely identified to remain in state care with a transition to SEVTC. All others have an ability and desire to transition to a community nursing facility or waiver group home or sponsored residential placement.

Advocates from the Disability Law Center have repeatedly emphasized the urgent need for enhanced behavioral supports within community settings. There is concern that the private sector, driven by cost-benefit analysis, may be unwilling to support individuals with high behavioral and medical needs without additional financial incentives. As a potential solution, stakeholders have proposed establishing preemptive funding streams, such as DAP or similar mechanisms, to offset the costs of providing higher levels of behavioral support.

Further, concerns were raised regarding forced discharges or evictions from community or private nursing facilities when behavioral support needs cannot be met. Such discharges place individuals at risk of destabilization and often result in their return to state-operated facilities.

The subcommittee has also called for a consistent and formalized pre- and post-move monitoring process for all individuals transitioning from HDMC, regardless of diagnosis. This approach aims to ensure that new placements are safe, supportive, and capable of meeting each resident's unique needs. Additionally, a recommendation for establishing supports beyond the current six-month monitoring period for all individuals.

Financial and infrastructure challenges persist. The $94 million renovation cost for HDMC, alongside a two-year evacuation requirement, raises feasibility concerns. Full facility replacement, estimated at $145 million, also requires significant investment. Request was made for a cost analysis of the smaller build of HDMC but was not available at the time of this report. The assumption is the cost would be less than that of a full facility replacement. Upgrading SEVTC homes to skilled nursing standards has been partially implemented, with advocates recommending additional home conversions to expand placement options.

The subcommittee continues to advocate for the creation of regional support centers modeled after the Office of Integrated Health (OIH) framework, to deliver consistent, statewide resources for individuals transitioning from HDMC.

The ongoing work of this subcommittee reflects a collective commitment to safeguarding vulnerable populations, addressing placement limitations, enhancing community-based care options, and ensuring that all individuals, regardless of medical or behavioral complexities, have access to safe, supportive environments.

VII. Quality Assurance and Risk Mitigation if Applicable

When planning transitions to community settings, several placement options are considered, including SEVTC, traditional and specialized nursing facilities, community intermediate care facilities, Medicaid waiver-funded residential programs for individuals with ID/DD, and ongoing development of specialized group homes for individuals with mental illness. Stakeholders also expressed the need for more options for individuals with ID and behavioral needs that HDMC cannot serve due to its vulnerable resident population.

The discharge planning process for individuals with ID/DD is comprehensive and collaborative. It begins with a needs assessment involving the individual, their Legal Guardian (s), or Authorized Representative (s). The Admissions & Discharge Coordinator (s) are fully reviews current medical, nursing, and therapeutic services, identifies essential supports, and ensures all necessary equipment and supplies are in place. Stakeholder meetings are held to determine whether the chosen group home or community provider can meet the individual's needs. If so, training is provided for group home staff, trial visits are arranged, and post-discharge monitoring is conducted within set timeframes to ensure a smooth transition. If additional training is provided and the group home provider feels that they are still not capable of providing the needed care for the resident, the resident has the option to return to HDMC. (Attachment B- detailed description of ID/DD Discharge Planning Process)

However, the subcommittee identified a gap in post-move monitoring for individuals with mental health or neurocognitive disorders. Advocates, including the Disability Law Center, strongly recommended establishing post-move monitoring for all individuals transitioning from HDMC, regardless of diagnosis, to ensure safety and adequate support in their new settings.

IX. Implementation Timeline

A timeline for the construction of a smaller HDMC is not available at this time. The transition of individuals into alternative settings has been identified to take around 18 months from the time of this report. At the time of this report three patients were currently in active discharge planning and projected to be transitioned by August 2025. 10 additional patients were projected to be discharged by December 2025. Of those 10; five are identified for community NH placement; four to waiver group homes and 1 would return to VCBR. Beginning in March of 2026 there are 14 additional patients that could work toward discharge. Initial review notes one could go to a community ICF; 8 to community nursing facilities and 6 to waiver homes. Of the remaining residents five would likely choose state care at SEVTC expansion SNF beds once complete in the latter par of 2026.

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X. Monitoring and Evaluation

The subgroup was adamant that enhancements be made to the monitoring processes already in place for "post move monitoring". In addition to assuring these processes are in place for all populations at HDMC there was a strong recommendation that we expand the timeframe to monitor the individuals for more than 6 months. A suggestion was made that continuous monitoring be in place for these individuals. Additionally a process and acknowledgement that part of planning and evaluation should be to account for any transfer trauma that may occur.

Its acknowledged that this planning subgroup was focused on the current residents at HDMC, however in planning for those individuals it was nearly impossible to separate the work from that of the subgroup planning on community. These subgroups worked closely together and recommendations from group should be looked at together and in context of each other as each affect the other.

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XI. Appendices

Attachments:

A- HDMC Residents' Survey (7/17/25) and Survey Results

B- HDMC Current Discharge Planning Process (ID/DD)